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CONSIDERATION OF VARIOUS LEGISLATION AND THE VA'S ADMINISTRATION OF THE VOCATIONAL REHABILITATION PROGRAM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

ON

S. 2462, S. 2463, S. 2207, S. 2396, S. 2446, S. 2459, S. 2293, S. 2294, S. 2394, S. 2419, AND S. 2464; AND OVERSIGHT OF THE VA'S ADMINISTRATION OF THE PROGRAM OF TRAINING AND REHABILITATION FOR VETERANS WITH SERVICE-CONNECTED DISABILITIES UNDER CHAPTER 31

JUNE 16, 1988

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CONSIDERATION OF VARIOUS LEGISLATION AND THE VA'S ADMINISTRATION OF THE VOCATIONAL REHABILITATION PROGRAM

THURSDAY, JUNE 16, 1988

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room SD-106, Dirksen Senate Office Building, Hon. John D. Rockefeller IV presiding.

Present: Senators Cranston, Rockefeller, and Murkowski.

Also present: Senator Durenberger.

Senator ROCKEFELLER. This hearing will come to order.

I am delighted to recognize the chairman of the committee, Senator Alan Cranston, who is graciously letting me preside over this hearing.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Senator CRANSTON. Thank you very much Jay, and I thank you for chairing this hearing. This is very, very helpful.

I join Jay in welcoming all of you to this hearing on various VA legislative and oversight issues. I want to add that Jay has been an active, contributing member of this committee ever since coming to the Senate 3½ years ago, and I deeply appreciate his help not only today but in all days as this committee does its work.

With respect to the matters before the committee today, I have a detailed prepared statement that is available at the press table. It provides descriptions of the bills under consideration and some preliminary thoughts regarding the administration of the chapter 31 program.

I would simply note briefly a few items at this point:

Many of the provisions of S. 2462 which were introduced on May 27 are aimed at improving the VA's ability to recruit and retain qualified health-care professionals. I am very deeply concerned about the health-care personnel shortage that the VA is experiencing, and I will be doing all I can to achieve the enactment of these provisions.

I also wish to stress the importance of S. 2463, legislation I introduced on May 27, to establish five VA mental illness research, education, and clinical centers, called MIRECC's. This measure would establish three centers of excellence as ways of responding to the need for increased VA research in mental illness and enhanced treatment of psychiatric disorders in VA facilities.

On Tuesday, I introduced S. 2511 which would establish a pilot program to provide certain assistive animals to certain service-connected disabled veterans who are quadriplegics or hearing impaired. Because the furnishing of assistive monkeys is a novel approach to meeting the needs of quadriplegic veterans, and there remain a number of questions to resolve regarding the provisions of these animals, I believe that a 3-year pilot program is the best approach. I am delighted that the VA has endorsed that approach.

I will be asking witnesses at today's hearing to provide their views on this legislation for the record.

I congratulate the committee's ranking minority member, Senator Murkowski, on his initiative in this area, S. 2207, and I look forward to working with him on a measure we can both support.

I want to especially express my thanks to today's witnesses for their very supportive testimony on the provisions of the various bills I authored or cosponsored which are before the committee today. Thanks also for the constructive recommendations for improving them. I also thank all witnesses for getting their prepared statements to us in advance. It has been very helpful.

My appreciation goes equally to the VA, which had a great number of legislative provisions on which to take positions in a very short period of time. The testimony was generally very constructive and positive, and I appreciate the efforts of all those involved at the VA to be both timely and responsive.

This morning we will be looking closely at the VA's administration of the program of vocational rehabilitation services and assistance for service-connected disabled veterans under chapter 31. I authored major reforms in this program in 1980, and I am very concerned by a recently issued VA Inspector General report which raises serious questions about the program's employment impact, application of eligibility criteria, and general administration. For disabled veterans we want only the best services, and I am not sure that is happening under chapter 31.

Two particular issues regarding the vocational rehabilitation program concern me greatly:

First, since the adverse impact that budget constraints appear to be having on the quality and timeliness of the vocational rehabilitation services to disabled veterans, I believe we need to provide for expanded use of contract counseling, and to do so with funding provided through the readjustment benefits account.

We took a similar approach in section 11A of my bill, S. 999, enacted on May 20, 1988, which established a program of job readiness skills to open counseling for Veterans' Job Training Act participants to be funded through the readjustment benefits account. This approach would appear to have great promise, both for the provision of comprehensive counseling and assessment services to nondisabled veterans participating in VA GI bill programs and currently served by VA counseling psychologists, and for the nonservice-connected vocational training participants who are also so served.

I note that at my suggestion the VA began, in 1987, to use its current authority to contract for the provision of evaluations for veterans under chapter 31, but I doubt it is doing so extensively enough.

Finally, I note my great disappointment over the many delays in the VA's conduct of a cost-benefit study and program evaluation of the chapter 31 program that was requested by the Veterans' Advisory Committee on Rehabilitation some 3 years ago. This study was supposed to be completed this year, but it will not be completed until 1990, thus delaying until that time the use of the study's findings to improve the chapter 31 program, and I think that is most regrettable.

Before closing, I wish to make several announcements:

First, I will introduce shortly and will also propose at our June 29 markup additional legislation related to PTSD. This legislation would require the VA to furnish, on a priority basis, needed inpatient and outpatient mental health services to Vietnam veterans who are diagnosed by the VA Department of Medicine and Surgery as suffering from PTSD that is related to their service.

In the recently released Vietnam Experience Study, the CDC found that 14.7 percent of all Vietnam Veterans have experienced combat-related post-traumatic stress disorder, and that 2.2 percent of the veterans in this study had this disorder during the months before their examination. That translates to 450,000 and 66,000 veterans, respectively.

Preliminary indications from data collected by the Research Triangle Institute indicate that the CDC estimates are in no way overblown. In view of the extent of this problem among Vietnam veterans, I believe it is fully appropriate and necessary to direct the VA to provide care and services to Vietnam veterans with PTSD related to their service.

Under this legislation, VA care for the Vietnam veteran with war-related PTSD would be forthcoming immediately on a priority basis, without the need for a formal adjudication of service connection.

I would also like to announce that at our committee's June 29 markup I will once again be proposing legislation which the Senate has previously passed on six occasions since 1979 to extend VA education benefits eligibility periods to those who have been prevented from pursuing their educations by alcohol or drug dependencies.

With the recent Supreme Court decisions in the *Traynor* and *McKelvey* cases, it is now clear that no judicial relief is available. It is up to the Congress to correct this situation. Those decisions have sparked considerable interest in this area, and I am hopeful that we may finally be able to achieve enactment of these constructive provisions.

I would like to mention two brief scheduling matters. We have scheduled an August 11 oversight hearing on VA health care. It seems clear that VA medical centers are currently experiencing very severe funding problems. We need to examine carefully the administration's response to this apparent crisis at many facilities and the viability of its position, at least up to this point, that no supplemental fiscal year 1988 funds are needed.

Second, our PTSD oversight hearing will be held on July 14, not July 7. That will also be a very important hearing.

Finally, again I congratulate and thank Senator Rockefeller for his great interest and fine leadership in this committee, and I thank you, Jay, for chairing this hearing today. Thank you very, very much.

[The prepared statement of Chairman Cranston appears on p. 142.]

Senator ROCKEFELLER. Senator Cranston, the honor is mine, very obviously, and I am grateful for your willingness to let me do it.

OPENING STATEMENT OF SENATOR ROCKEFELLER

Senator ROCKEFELLER. Today's hearing addresses no less than 11 bills, introduced by Chairman Cranston, myself, Senator Murkowski, and other committee members.

First are S. 2462, designed to maintain and improve the VA's ability to meet the health-care needs of our Nation's veterans and their dependents, which was introduced by Chairman Cranston, myself, and Senators Matsunaga and DeConcini; and S. 2463, also introduced by the four of us and Senators Murkowski and Graham, to improve VA care for veterans with mental illness through the designation of five mental illness research, education, and clinical centers; two bills that I introduced and which are cosponsored by the chairman are also under consideration.

My two bills are: S. 2446, to extend for 1 year the VA's authority to furnish respite care to certain chronically ill veterans and the due date for a VA report on its evaluation of such care; and also, S. 2459, which Senator Murkowski joined us in introducing, to extend for 1 year the temporary program for vocational training for certain veterans pension recipients.

We will hear testimony also on S. 2207, a bill introduced by Senator Murkowski, to authorize the VA to provide service-connected quadraplegic veterans with assistive animals.

In addition, Chairman Cranston is asking the witnesses to submit their views on his bill, that one being S. 2511 introduced on Tuesday to establish a pilot program in this area.

S. 2396, a bill introduced by Senators Mitchell and Cranston, would expand the period considered as the Vietnam era in the case of veterans who served in the Republic of Vietnam. That will also be considered.

Finally before us are five bills which the chairman introduced at the request of the administration: S. 2293, to increase the dollar limit on VA construction projects considered minor projects; S. 2294, the proposed Veterans' Administration Health Care Amendment Act of 1988; S. 2394, to authorize the appointment of VA-trained graduates and certain health-care professionals without regard to civil service hiring procedures; S. 2419, the proposed Veterans' Housing Amendments Act of 1988; and S. 2464, to authorize the VA to pay interest on insurance settlements and increase discounts for premiums paid in advance.

As I have mentioned, this morning we will also be reviewing a very important program—that is, the VA's program of vocational rehabilitation services and assistance for service-connected disabled veterans under chapter 31 of title 38. We will be probing the findings of the VA's Inspector General on this program, which suggest these are serious deficiencies in the program's administration. We will also hear testimony from the service organizations that major objectives of the reforms enacted in 1980 have not yet been achieved.

It seems clear from the testimony that budget constraints are having an adverse effect on the quality and timeliness of vocational rehabilitation services provided to disabled veterans by the VA's vocational rehabilitation specialists and counselors.

We plan to explore these issues vigorously this morning. Those who have had their lives interrupted, often at great personal cost, in order to defend our freedom and preserve our Nation's security deserve high-quality health care, readjustment, rehabilitation, and veterans' benefits programs.

Thus, I am delighted to have the chance to work on these important legislative matters and oversight issues that we will be dealing with today.

We have a full agenda, a distinguished array of witnesses, and therefore I have to be particularly vigilant about this small box before me, and I would encourage all to complete their testimony within 5 minutes. You know, of course, that all of your testimony will be put, in full, in the record.

So I would like to welcome as our first witness this morning Mr. Donald Ivers, General Counsel of the Veterans' Administration, accompanied by Dr. Daniel Winship, Assistant Deputy Chief Medical Director for Programs and Operations of the VA's Department of Medicine and Surgery.

Gentlemen, good morning.

Dr. Ivers, please proceed.

STATEMENT OF DONALD L. IVERS, GENERAL COUNSEL, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. DANIEL H. WINSHIP, ASSISTANT DEPUTY CHIEF MEDICAL DIRECTOR FOR PROGRAMS AND OPERATIONS, DEPARTMENT OF MEDICINE AND SURGERY

Mr. IVERS. Thank you, Senator Rockefeller.

I am pleased to be here today, along with Dr. Winship, to represent the VA, to discuss the array of legislative initiatives on the agenda.

In that regard, we very much appreciate your efforts and those of the chairman and ranking minority member of this committee in introducing and placing on the agenda for today for consideration a number of VA's proposals affecting various Agency programs.

We have submitted a detailed statement for the record on each of these proposed pieces of legislation, and I will attempt in the 5 minutes allotted to summarize our position on most of these bills.

The first bill, S. 2462, a bill introduced by Senator Cranston and cosponsored by yourself, contains a number of provisions. It is an omnibus health-care bill. The first provision would expand the eligibility for readjustment counseling to Lebanon, Grenada, World War II, and Korean veterans.

The VA's position on this bill is that we would oppose the expansion to World War II and Korean veterans but see no problem with the post-Vietnam era veterans.

Another provision would extend the Philippine contract authority and grants for 3 years. We support that bill, but we have recommended that it be extended to a 5-year period rather than 3 years.

Another provision would authorize the Veterans' Administration to appoint graduates trained in VA facilities, without regard to civil service procedures. We very much favor that provision and in fact have recommended legislation to that effect as a separate bill.

Another provision would shorten the period for the Office of Personnel Management to disapprove VA's special pay rates, and we favor that provision.

Another provision would narrow those situations where a disciplinary board would be required and would extend union grievance arbitration to title 38 employees. We generally favor that bill and have commented extensively on it in our written testimony.

Another provision of S. 2462 would add flexibility to VA sharing authority, and we clearly favor that.

An additional provision would authorize grants to allied health institutions. The Veterans' Administration has not had time at this stage to fully study that proposal and are not prepared to comment either favorably or unfavorably on that proposal at this time.

Another provision would require a 3-year pilot program at five VA medical centers to study measures to enhance recruitment and retention of nurses and other scarce medical professionals. We favor that approach. We have in our full testimony recommended a number of changes that we think would make it a more feasible and more administratively workable bill, and we hope that we will be able to work out an agreement on that bill. We generally favor the approach.

Finally, under S. 2462 is a provision requiring existing special committees on PTSD to make additional reports. We do not oppose that provision.

Another bill before us today is Senate bill 2207, which was introduced by Senator Murkowski. This bill would authorize the Veterans' Administration to provide simian aids and assistive dogs to veterans receiving compensation for quadriplegia. At the present time we do not support that bill as it is written; however, we have noted that Senator Cranston recently introduced S. 2511, which is a bill similar in nature that would provide for two pilot programs, one to provide simian aids and the other to provide signal dogs. We very much support the pilot program approach in this area at this time.

One of the bases for that is that at the present time it is our understanding there are not sufficient animals trained in this area to be available to all veterans who might want or need them, and we think this pilot program approach, along with some additional research and study and training is a much more appropriate way to approach this.

Another bill, S. 2459, introduced by you, Senator Rockefeller, and cosponsored by the chairman and the ranking minority member would extend for 1 year a program to provide vocational training to certain VA pensioners. We support the extension; however, we would recommend a 3-year extension as opposed to a 1-year extension and make the participation in the program voluntary rather than mandatory.

In your introductory remarks, Senator, you fairly well covered most of these bills and, rather than go much further over my time, I think I will submit our statement. We stand ready to respond to any questions that you have.

[The prepared statement of Mr. Ivers appears on p. 166.]

Senator ROCKEFELLER. Thank you, sir.

Senator Cranston asked me to raise an issue with you. There have been discussions between committee staff and the VA staff about the types of appointments that nonphysician VA medical center directors in DM&S presently receive under title 38.

I understand that there is considerable sentiment among those directors that they be appointed under the title 5 senior executive service authority rather than under title 38.

I further understand that legislation has been prepared by the Agency which would change the nature of these appointments in this way.

(a) Can you please tell us the present status of that legislation and when we might expect to receive it?

(b) Mr. Ivers and Dr. Winship, in connection with any legislation in this area, the committee would appreciate your considering whether there would be any serious problem with providing in such legislation that those directors who wish to do so would be entitled to remain under the title 38 system for as long as they served as VAMC directors.

Mr. IVERS. Senator Rockefeller, that draft legislation that has been prepared by the Veterans' Administration is currently pending at OMB. However, we have been advised that there is no strong opposition to it. I believe they are waiting for some additional comments from at least one of the other agencies that would be affected by this.

There is support. And Dr. Winship can correct me if I am wrong, but I believe there is strong support among the directors for legislation. We support it.

Insofar as grandfathering in any directors who might not wish to fall under title 5, under the SES, I don't believe there would be any problem with that. It would make administration of disciplinary procedures, et cetera, a little more complex; but I don't think there would be any overwhelming objection to that.

We anticipate receiving a final clearance on that bill certainly by next week, if not by the end of this week.

Senator ROCKEFELLER. Very good. Thank you.

Also, Mr. Ivers, I note that Agency testimony does not support that portion of section 2 of S. 2462 which would expand eligibility but not provide an entitlement for readjustment counseling to World War II and Korean conflict veterans.

As I am sure you recall, Administrator Turnage, when he was describing the VA's recent approach to the readjustment counseling program during our committee's March 4 hearing on the VA's fiscal year 1989 budget, said, "But let me suggest one other thing about the attitude we have had: We said 'don't only treat Vietnam veterans; treat active duty types; treat World War II types; treat Korean veterans, or anyone else who needs that kind of help.' "

My first question would be: I understand that this was not a new statement on the part of the Administrator, but that he has made similar statements in other forums. Does the Agency's position in the prepared statement mean that Administrator Turnage no longer adheres to what he testified to on March 4?

Mr. **Ivers**. No, Senator. The Administrator's position, from that testimony and other statements that he has made, he felt at the time he was commenting on the situation as it currently exists, where we have been advised that World War II and Korean veterans have been appearing on occasion at vet centers for counseling.

There is no support in the Agency at this time for expanding that program to include World War II and Korea. We feel that the current programs that are available within the VA medical system are adequate to address those problems with respect to World War II and Korea.

Again, we do not oppose expansion of the program to include the post-Vietnam era readjustment counseling.

Senator **Rockefeller**. But if they come in, can they get treated?

Mr. **Ivers**. We would prefer, Senator, as I have indicated, that they be referred through the regular VA medical channels. I think this is appropriate, particularly in light of the stated purposes of the Readjustment Counseling Program, which was to assist veterans coming back in the readjustment period immediately following the conflict, particularly one like the Vietnam war, which was an unpopular war both here and abroad. Those of us who returned from Vietnam were faced with a slightly different set of problems than those addressed and treated by the VA with respect to World War II and Korean veterans.

Senator **Rockefeller**. So, he does not, then, adhere to his previously stated position?

Mr. **Ivers**. He did not intend at that time to state a VA policy that we would support the expansion.

Senator **Rockefeller**. Thank you.

Then would it be acceptable to provide eligibility, so long as the VA had no obligation to engage in outreach to these veterans of other wars?

Mr. **Ivers**. As I stated previously, we do not feel that an expansion of the Readjustment Counseling Program to World War II and Korean veterans would be appropriate at this time.

Senator **Rockefeller**. OK.

Dr. Winship, I have some specific questions about the experience of the vet centers with furnishing counseling services to veterans from prior wars.

And I would appreciate it, Dr. Blank, sir, if you wouldn't mind, your coming forward for a moment to respond to my questions. I would appreciate that.

Thank you.

Dr. Blank, do you have any estimate of the number of World War II and Korean conflict veterans that the vet centers are now seeing?

Dr. **Blank**. We are currently seeing around 375 new World War II clients per month in vet centers nationwide, and on the order of 400 Korean veterans per month. That is nationwide, also.

Senator **Rockefeller**. Thank you.

Has there been any increase in demand for readjustment counseling services from this population over the years that you have headed up the vet center program?

Dr. BLANK. We have seen no increase of arrival of new World War II veteran clients at vet centers. There has been an increase from 1986 to 1987, which are the points that we have measured this, an increase in the number of Korean conflict veterans coming, on the order of 25 percent.

Senator ROCKEFELLER. And for what types of assistance are they coming to you?

Dr. BLANK. There is a considerable variety. A number of these veterans are self-referred on the basis of what they have heard from Vietnam veterans about the effectiveness of readjustment counseling services.

Not infrequently they are uncles or fathers or older brothers of Vietnam veteran vet center clients. Some of them have post-traumatic stress disorder which has previously been undiagnosed and untreated.

Senator ROCKEFELLER. Is there any sense of the proportion of those?

Dr. BLANK. No, we do not have hard estimates of the proportions.

Senator ROCKEFELLER. You don't have them in hand?

Dr. BLANK. We have not obtained them from the field.

Senator ROCKEFELLER. Would it be possible to do that?

Dr. BLANK. Yes, it would.

Senator ROCKEFELLER. And submit that to the committee for the record?

Dr. BLANK. Yes.

Senator ROCKEFELLER. Thank you, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

The following results were gathered from a field survey of all vet centers during July 1988, in response to a request from Senator Rockefeller during the June 16, 1988, hearing of the Senate Veterans' Affairs Committee. This information is regarding the problems of combat veterans of prior wars presenting for services at vet centers. The results are set forth as the total number of problems reported by the total number of veterans for the specified era. Because some veterans reported experiencing more than one problem, the number of problems reported is greater than the number of veterans seen for both eras, World War II and Korea.

Results of Problem Survey on Non-Vietnam Era Veteran New Clients
(July 1-31, 1988)

Total number of new clients seen:	
World War II	376
Korean War	364

World War II (376):	*Number of clients with problems*
PTSD	47
Drug/Alcohol	43
Marital/Family	17
Psychological, other	39
Employment	40
Benefits	170
Medical	28
Basic needs	45
Legal	5
Other	18

Korean War (364):	*Number of clients with problems*
PTSD	55
Drug/Alcohol	53
Marital/Family	22
Psychological, other	46
Employment	98
Benefits	123
Medical	50
Basic needs	19
Legal	12
Other	15

Senator ROCKEFELLER. Where are vet center personnel referring these veterans for assistance?

Dr. BLANK. Probably the majority are being referred to VA medical centers, most often to VA mental hygiene clinics, for services. Others are being referred, depending on the locality, to private sector sources.

Senator ROCKEFELLER. All right.

What do you believe would be the impact in terms of workload on the existing vet centers if the agencies were given the authority to provide readjustment counseling services to these veterans?

Dr. BLANK. There are no systematic studies about such problems in World War II and Korean veterans, so our estimates or predictions are based on our current experience and clinical experience. But, in general we feel, because of the time that has elapsed, that the workload impact would be marginal, and the numbers of veterans involved would be quite small.

Senator ROCKEFELLER. I see. Thank you very much, Dr. Blank; I appreciate your answers.

Mr. Ivers, Senator Matsunaga will shortly be introducing a bill which would require the VA to conduct a comprehensive study of the prevalence and instance of psychological problems, including post-traumatic stress disorder, in the population of Asian-American and Polynesian-American Vietnam veterans. Would you please expedite the VA's comments and cost estimates on this bill so that the committee can have the information by June 24 in time to consider that for a June 29 markup?

Mr. IVERS. We will do everything we can, Senator. We have not yet seen that legislation, so I couldn't really comment on it at this point. We will do everything we can to provide the information required.

Senator ROCKEFELLER. We will get you a draft post-haste.

Mr. Ivers, on page 13 of your testimony, you state that the VA lacks legal authority for pilot projects in the area of pay compression and flexible employee benefits. You therefore recommend modifying section 9 of S. 2462 to add specific additional authorities for testing methods to ameliorate pay compression and to provide flexible employee benefits. Would you please provide as soon as possible, as a technical service, draft positions for the pilot program authority that you feel are desirable?

Mr. IVERS. Certainly. I would be glad to.

Senator ROCKEFELLER. Dr. Winship, on June 9 Senator Cranston submitted a prehearing question regarding the administration's request for an increase in the fiscal year 1989 appropriation for grants for the Veterans' Memorial Medical Center in Manila. He asked for a response by June 13. Nothing has yet been received. Would you please expedite an answer for the chairman's question?

Dr. **Winship**. Yes, sir.

Senator **Rockefeller**. Would you be able to get us an answer by tomorrow afternoon?

Dr. **Winship**. Yes.

Senator **Rockefeller**. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

Question. 1. The Administrator sent on April 7, 1988, a letter to the President of the Senate containing a draft bill for legislative consideration, which I introduced (by request) on April 18. One provision, section 5(b), would extend the administration's authority (which currently expires at the end of Fiscal Year 1989) through 1994 to make grants of up to $500,000 annually to the Veterans Memorial Medical Center (VMMC) in Manila, Philippines, for the purpose of replacing and upgrading equipment and for rehabilitating the physical plant. On May 10, 1988, the Administrator sent a letter to Senator Proxmire, Chairman of the Subcommittee on HUD-Independent Agencies of the Committee on Appropriations, requesting an increase of $500,000 for Fiscal Year 1989 raising the total appropriation requested for the program to $1 million for that fiscal year.

1A. For what specific purpose will the additional $500,000 be used

Answer. We anticipated that the additional $500,000 would be used to procure radiology equipment, rehabilitation medicine equipment and ICU monitoring equipment.

Question. 1B. Why is the administration not proposing to increase the $500,000 figure to $1 million for Fiscal Year 1989.

Answer. While we believe that there is need for this additional equipment for the VMMC, upon a further review of budget priorities for Fiscal Year 1989, we do not believe that we can justify an additional $500,000 grant request at this time for the VMMC in light of our obligation to meet the mandates to provide quality health care to eligible veterans in our own facilities and the constraints of VA resources. Therefore, we are withdrawing our request to the Appropriations Committee at this time for an additional $500,000 for the VMMC.

Question. 1C. What is the current unobligated balance for this program?

Answer. A total of $500,000 was provided for the Grant-In-Aid Program in fiscal years 1987/1988.

A total of $480,000 was provided for the fiscal years 1988/1989 program. Of this, $294,471 remains unobligated as of the end of June 1988.

The facility has numerous items for which the remaining funds will be used. However, it is prudent to maintain an unobligated balance to allow a cushion in the event of severe unexpected emergencies.

The following are examples of projects and equipment purchases which could be accomplished in the future:

	Estimated costs
Projects:	
Emergency generator	$90,000
Roof repairs/waterproofing	120,000
Water distribution system	150,000
Renovation of rehabilitation medicine	40,000
Equipment:	
Radiology equipment (1 X-ray unit and 2 ultra sound units)	430,000
Rehabilitation medicine equipment	70,000
ICU monitoring equipment	100,000

Question. 1D. Are the additional funds being requested for Fiscal Year 1989 necessary only for this fiscal year or is additional funding being anticipated for future fiscal years?

Answer. The additional $500,000 being sought for fiscal years 1989/19[illegible] are requested on a recurring basis.

Senator **Rockefeller**. Dr. Winship, on page 16 of the VA's written testimony it is stated, in regard to the provision of assistance monkeys to quadraplegic veterans, that the VA welcomes the progress that has been made in this area and is "proud to have supported it financially."

As you may be aware, Dr. Willard has requested further funding from the VA in order to complete the research phase of the program over the next 18 months.

In light of the VA's expressed pride in and appreciation for Dr. Willard's work, what are the VA's plans to renew its research support for this program?

Dr. WINSHIP. Senator Rockefeller, the research support is in an interim status right now while we are trying to determine how to continue the support of this particular program.

One of the issues, of course, is that the program has been in a research mode for several years and has been appropriately supported with research funding. It has achieved a level at which it is now appropriate to entertain and undertake clinical trials or to have this enter into the clinical arena, and therefore the basic research support for this may no longer be appropriate.

I would like to have Dr. Margaret Giannini make further comments on this about how we plan to approach this, if that is acceptable.

Senator ROCKEFELLER. Dr. Giannini? Please.

And Doctor, you will forgive me, I must go and vote. Jon Steinberg will be chairing until I return.

Mr. STEINBERG. Doctor, please proceed.

Dr. GIANNINI. I believe what Dr. Winship was alluding to is that, since we have completed the rehabilitation research aspect of the basic hypotheses, we are proceeding according to our policy that we now are looking at an evaluation proposal which we had requested Dr. Willard to submit. That is in process.

Unofficially it looks quite positive. We will probably proceed, once all of our observations are in order and our decisions are sound—proceed to do the evaluation and make some decisions at that point as to how can we transfer this type of technology into the health-care delivery system.

Mr. STEINBERG. Senator Cranston will be submitting to the Agency a written question at the conclusion of the hearing, which deals with the authority under either the Murkowski bill or the Cranston bill for the Agency to make advanced partial payments prior to the placement of the simian. I think this is something Dr. Willard is very concerned about, and we would appreciate your expedited consideration of that question and a prompt response.

Thank you for your answer.

Dr. Winship, the VA's testimony states that the VA is not prepared to support section 8 of S. 2462 which would authorize the appropriation of funds for grants to post-secondary schools for, among other things, the expansion and improvement of professional health-care educational programs. This is currently the third subchapter of chapter 82, as you know.

It is also stated in your testimony that sufficient time has not been available to assess the impact that such a program could have on the VA's ability to meet its medical personnel needs.

Between 1972 and 1979, when this program was first enacted, 135 grants were made under it. Was that program successful in making available additional health-care personnel, in your opinion?

Dr. WINSHIP. In my opinion it was.

Mr. STEINBERG. Do you have any reason to believe that you would not have similar success were the program renewed today?

Dr. WINSHIP. No, I do not.

Mr. STEINBERG. That concludes the questions that Senator Rockefeller and Senator Cranston had for you. We do have a substantial number of written questions, and we plan to give them to you before the hearing is over today.

Since we are on a very short timeframe, we would greatly appreciate it if you could get responses back to us by the close of business next Wednesday if at all possible, which I believe is the 22d.

Again, Mr. Ivers and Dr. Winship, we thank you very much for your presence here this morning.

Mr. IVERS. Thank you.

Dr. WINSHIP. Thank you.

Mr. STEINBERG. Our next witnesses are Dr. Dennis Wyant, Director of the Vocational Rehabilitation and Education Service in the VA Department of Veterans' Benefits, and Mr. Renald Morani, Acting Inspector General of the Veterans' Administration.

In order that Senator Rockefeller may be here for as much of your direct testimony as possible, I am going to proceed out of order and propound direct questions to you at this point, and then break off with any such questions at the time of Senator Rockefeller's return.

May I ask, first of all, if each of you would introduce those who are accompanying you?

Dr. Wyant.

Dr. WYANT. Thank you, Mr. Steinberg. I am accompanied by Jim Reed, who is Assistant Director for Vocational Rehabilitation Counseling, Vocational Rehabilitation and Education Service in our Central Office.

Mr. MORANI. Mr. Steinberg, on my far right is Ken Furukawa, who is the Assistant Inspector General for Auditing. On my left is John Meche, the Audit Manager for the subject audit for discussion.

Mr. STEINBERG. Dr. Winship, could we ask if you would please join the panel as well, since we will have some questions regarding vocational rehabilitation to address to you?

We will start with questions for Dennis Wyant.

Dennis, on page 2 of your testimony you state that six regional offices use contract counseling centers to provide educational and vocational counseling services to VA education program participants—that is, participants other than chapter 31 participants.

Can you tell us why only six offices are involved in doing this?

Dr. WYANT. Yes, I would be glad to, Mr. Steinberg.

As you know, that number has decreased over the years. A regional office director, when taking general operating expense money, and deciding whether to spend that internally on staff or to contract out for services, the majority have correctly decided to keep staff and use those funds within their regional office.

Mr. STEINBERG. So there was a larger number several years ago than six?

Dr. WYANT. Yes.

Mr. STEINBERG. Are you doing any contracting in connection with the vocational training program?

Dr. **Wyant**. Certain employment services. Basically, most of it has been done in-house.

Mr. **Steinberg**. Do you have any estimate of the dollar volume of contracting that is being done, either as to education participants or vocational training participants?

Dr. **Wyant**. I would be glad to provide that to you for the record. I don't, offhand.

Mr. **Steinberg**. And the numbers of participants involved, which obviously would be entailed in developing the cost estimate.

Dr. **Wyant**. Yes.

Mr. **Steinberg**. Do you not believe that it would be desirable, in order to be able to focus more of your direct in-house staff on veterans with service-connected disabilities, for you to do more contracting than you are presently doing?

Dr. **Wyant**. As the chairman mentioned in his opening statement, Mr. Steinberg, we did put out a circular in 1987 based on a meeting that we had had with your staff, because it does make good sense to try to maximize the use of community and other outside resources in conjunction with our present staff. It just gives us more bang for the buck when it is available.

Mr. **Steinberg**. Is that circular limited to extended evaluations, however, only?

Dr. **Wyant**. And employment services.

Mr. **Steinberg**. Do you have an estimate of the extent to which you are utilizing that contract authority at this point in terms of the dollar value of services, the number of veterans for whom services were contracted in 1987, and the estimate for 1988?

Dr. **Wyant**. Unfortunately, that data are not on an automated report, and it would have to be manually collected. If it is the desire of the committee, we can get that information for you.

Mr. **Steinberg**. Yes; if you would get for us the number of veterans for whom contracting was employed in fiscal year 1987 and the dollar value of those services, and where we stand in 1988, your estimate for the rest of 1988, and your estimate for 1989, please.

Dr. **Wyant**. Yes, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

The data for 1987 in the two categories are:

Number of disabled veterans provided extended evaluation by contract with cost to the VA—689.

Cost of contract service—$981,802.91.

Number of extended evaluations completed by DM&S facilities—95.

Number of extended evaluations completed by agreement with other agencies such as State DVR with no direct cost to the VA—110.

Employment Services:

Number of veterans provided employment services by contract—76.

Cost of contract employment services—$63,984.62.

The above data reflect the contracting activity during 1987 and it is anticipated that the extended evaluation contracting will be approximately the same for 1988 and 1989. Program emphasis is being directed toward greater utilization of contracting in areas of employment services and therefore an increase (20–30 percent) is anticipated in this area during 1988 and 1989.

Mr. **Steinberg**. Do you feel that you are currently making maximum use of contracts for extended evaluations and employment services?

Dr. **Wyant**. No, sir, we are not.

Mr. STEINBERG. What is the impediment to utilizing contracting for those services?

Dr. WYANT. One major impediment is only being able to contract with nonprofit organizations versus for-profit. It does really limit our resource base.

Mr. STEINBERG. So, if you were given authority to contract with appropriate for-profit entities, you would be able to utilize that authority more extensively?

Dr. WYANT. That is correct.

Mr. STEINBERG. Thank you. That is very helpful.

In 1983, the first phase of the chapter 31 modernization initiative was incorporated into the target system. Phase two of the chapter 31 payment system redesign is not currently planned for installation until late in 1989, as we understand it. Is that correct?

Dr. WYANT. That is correct.

Mr. STEINBERG. Is this system being developed under contract or by VA staff directly?

Dr. WYANT. By VA staff directly.

Mr. STEINBERG. Do you believe, Dr. Wyant, that this project is receiving the priority that it deserves in relation to other DVB modernization initiatives?

Dr. WYANT. The project has a higher priority now that the new Montgomery GI Bill has been implemented, and it is being given proper priority at this moment.

Mr. STEINBERG. How is the higher priority being manifested based on the Montgomery GI Bill?

Dr. WYANT. Basically, the chapter 31 system, even though it is a manual system that was developed in the sixties, does get our veterans paid the majority of the time. With the New Montgomery GI Bill, we had no system in place, and basically every available resource had to be used to develop a system so that we could get the new participants of the GI Bill program paid. That system was installed at the end of April, and we are now redirecting resources now back to development of the chapter 31 payment system.

Mr. STEINBERG. I don't quite understand the relationship between the New GI Bill being made permanent and the plan to bring computerization online with respect to chapter 31. You are still not scheduled to achieve that until late in 1989, approximately 18 months from now. Was that not the schedule prior to a year ago when the Montgomery GI Bill was made permanent?

Dr. WYANT. No, sir, that project has been backed up several times. I think, as a matter of fact, we originally thought it might be on as early as 1985 or 1986.

Mr. STEINBERG. That is exactly our impression. Again, it is our impression that this matter is not receiving the priority that a program for service-connected disabled veterans should receive in the Department of Veterans' Benefits, and we would appreciate it if you and the other Agency representatives here would express that concern to Mr. Vogel and to the Administrator, to see if anything can be done to move forward the 1989 date.

I believe, in the course of the testimony of this panel, we are going to see that the lack of computer support for the program is an important factor in your not having certain data available to demonstrate program success, and so forth. So we would greatly appreciate it if you would pursue that and report back to us on behalf of the Agency as to whether a greater priority can be afforded to computer assistance for chapter 31.

Dr. WYANT. We would be glad to.

[Subsequently, the Veterans' Administration furnished the following information:]

We are reviewing approaches to affording greater priority to computer assistance for chapter 31, without seriously jeapordizing ADP projects for other educational programs. We are also exploring techniques and associated resources needed to expedite the implementation of the chapter 31 payment system redesign. Resources were redirected to the New Montgomery GI Bill. Now that the essential elements of that system have been installed, those resources have been redirected back to the development of the chapter 31 payment system. This will improve the timeliness of the chapter 31 project.

Mr. STEINBERG. If we could just withhold for one moment, please.

[Pause.]

Senator MURKOWSKI. My statement has been submitted for the record, so go ahead with your questions, Mr. Steinberg.

[The prepared statement of Senator Murkowski appears on p. 163.]

Mr. STEINBERG. With Senator Murkowski's permission, I will proceed with the questions that Senator Rockefeller had for you.

According to page 7 of your statement, "The Agency began implementation of a computer-assisted guidance information system in fiscal year 1987 by providing funds for hardware and software to selected field offices." How many field offices were included initially?

Dr. WYANT. Initially 44 locations. That would be 20 regional offices and their outbased locations.

Mr. STEINBERG. And what is the current stage of that implementation?

Dr. WYANT. This year we would like to expand that to additional regional offices and complete the project in 1989.

Mr. STEINBERG. Calendar year 1989?

Dr. WYANT. Yes.

Mr. STEINBERG. What part of 1989?

Dr. WYANT. That hasn't been determined. It is just in our long-term plan—or short-term plan, however you like to look at it for calendar year 1989.

Expansion to additional offices is dependent on available funding—and you know what the budget is and how much we have in this account.

Mr. STEINBERG. What funding do you have in 1988 and what funding is in the 1989 budget request for this expansion?

Dr. WYANT. It is not an earmarked amount. It is part of the GOE account.

Mr. STEINBERG. Well, has the Agency at this point allocated funding for expansion, at least in fiscal year 1989, in its budget request for the GOE account?

Dr. WYANT. We do have some funding in there for that at this point, yes, sir.

Mr. STEINBERG. Would you provide more details on that for the record, please?

Dr. WYANT. Yes, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

Computer Assisted Information System (CAIS): The CAIS is a PC-based system which provides immediate and up-to-date counseling and rehabilitation information to professional staff and veterans. The CAIS includes the following components: (1) Guidance Information—an automated data base for exploration of up-to-date national and local information about occupations, educational facilities and programs, physical limitations by occupation, sources of financial aid, and armed services occupational information; (2) Functional Assessment Review—for use in improving rehabilitation planning with disabled veterans; (3) Microtest Assessment—on on-site administration, scoring, profiling and interpretation of a wide range of psychological and vocational assessments instruments; and (4) an employer prospect list for use in local labor markets to assist in placement of job ready disabled veterans.

Implementation Strategy: During Fiscal Year 1987, the guidance information and psychological assessment components of the CAIS were installed at 43 VR&C counseling locations. Activities during the first quarter of Fiscal Year 1988 focused on the efficient installation of CAIS components and timely training of staff. Strategy for the remainder of Fiscal Year 1988 calls for the expansion of CAIS to 11 regional office and outbased counseling locations, and development of the functional assessment and employer prospect list components.

In Fiscal Year 1989, the CAIS will be expanded to the remaining regional office and outbased counseling locations.

Estimated Costs: During Fiscal Year 1987, approximately $250,000 was spent to provide CAIS services at 43 counseling locations. A single site installation cost of approximately $6,000 is projected. Approximately $62,000 is budgeted for Fiscal Year 1988 and $180,000 in Fiscal Year 1989. It is estimated that this system will provide savings of approximately $0.5 million over a 5-year period and most importantly improve the quality of service.

Mr. STEINBERG. As we understand it, that system is run off of a personal computer which provides up-to-date educational and career guidance information, and also testing during the rehabilitation counseling process. Is that correct?

Dr. WYANT. Yes.

Mr. STEINBERG. To your knowledge, do State VR counselors generally use or have available to them this kind of personal computer system for education and career guidance information?

Dr. WYANT. We were not a pacesetter in this field. It has been used by States. Probably more States don't have it than do have it, but the more progressive States are using this system, and particularly private rehabilitation facilities.

Mr. STEINBERG. Thank you.

On page 11 of your written statement, you indicate that veterans in the chapter 32 Contributory Program and chapter 30 New GI Bill participants appear to request counseling at a lesser rate than veterans and dependents in other VA education programs. Do you have any explanation for this?

Dr. WYANT. Of course the numbers have been going down some in the education programs under chapter 34. However, as you mentioned, the New GI Bill and chapter 32 are growing programs.

Part of the explanation may be that in a decision 3 or 4 years ago the counseling block was taken off the application form. And perhaps the new participant doesn't realize that counseling is an option; however, this option is noted on the back of the form.

Mr. STEINBERG. When was that removed from the front of the form?

Dr. WYANT. It was before I took over the education service, so it was prior to October 1986.

Mr. STEINBERG. VA data show that initial processing time for an application for chapter 31 benefits has gone from 78 days in 1985 to 90 days in 1987, and extended evaluation services for severely disabled veterans went from 154 days in 1985 to 182 days in 1987. Yet, the budget request for 1989 calls for a decrease of 11 FTE down to 650. The VA budget request for 1989 states, "The requested FTE level for 1989 will provide continued good service to our veterans." Our question is: How can you provide "continued good service" with even fewer staff—that is, more staffing cuts?

Dr. WYANT. Mr. Steinberg, when that budget recommendation was initiated, we took into account that the pilot program under Public Law 98-543 would be winding down, and that evaluations, case management, and training would not be at the same level as they had been during this fiscal year and the prior fiscal year.

Mr. STEINBERG. That is voc training?

Dr. WYANT. Yes, under chapter 15.

Mr. STEINBERG. So that, with the administration proposal to extend that for 3 years and the pending legislation to extend it for at least 1, and therefore the likelihood that there will not be a wind down, the current staffing level requested in the budget would not appear to enable you to provide the good service that you seem to be referring to. Is that the inference we should take from what you just said?

Dr. WYANT. If the proposal does become law, this is a new factor that we have to take into consideration, in the formulation of any additional budgeting changes.

Mr. STEINBERG. Do you consider the types of delays that I outlined, 182 days in fiscal year 1987 for extended evaluation and 90 days before an application is processed, to be good service to service-connected disabled veterans?

Dr. WYANT. We are always trying to find ways to streamline the service with the staff that we have now and with the caseload that we have. We have taken several measures to try to streamline, to take out any kind of unnecessary action, so we can serve the veteran as quickly as possible. Under our present situation, we think we are doing the best with what we have got.

Senator MURKOWSKI. Excuse me, Jon. I want to apologize to the panel and apologize to you. I came in from another meeting and have been scheduled to meet with the Vice President, and I have a meeting starting at 10:30 with our Ambassador to Thailand on the issue of our relations with Cambodia and Vietnam. So I am also going to excuse myself, and Mr. Tony Principi the Minority Chief Counsel and Staff Director will be briefing me on the results of the hearing and participating with the panel.

I apologize, gentlemen and ladies.

Mr. STEINBERG. Thank you, Senator. We have your opening statement, which will appear in the record, of course.

Senator MURKOWSKI. Yes.

Mr. STEINBERG. Dennis, is it fair, then, to expect, with the staffing levels that are requested for 1989—650 FTE—and with the likelihood that the vocational training program will continue at at least the current 3,500 participant level, that the 90 day and 182 day figures will increase?

Dr. **Wyant**. We have been in a trend where the timeliness has increased. However, I would mention that with the CAIS system and with some of the other administrative procedures we are trying to use, we are looking for ways to try to whittle that away.

Mr. **Steinberg**. I must confess to being somewhat confused by your answer with respect to the quality of service that is available to veterans and the relationship to the extension of the vocational training program.

Was not the extension of the vocational training program as well as the administration's proposal reflected in your testimony to extend the program to pensioners who received pensions prior to October of 1985? Was that not in the original budget submission for fiscal year 1989?

Dr. **Wyant**. It was not.

Mr. **Steinberg**. So, that was an add-on after the figures were already set?

Dr. **Wyant**. That is correct.

Mr. **Steinberg**. And what efforts have been made by yourself on behalf of your service, by DVB, and by the Agency in connection with that new legislative proposal for you to receive the staffing that you need to carry out all of your functions including the vocational training program?

Dr. **Wyant**. Anytime that a bill is introduced, the staff starts doing some preliminary work; once that bill becomes law a formal package would be going forward telling about additional needs that would be caused by new legislation.

Mr. **Steinberg**. We would very much appreciate it, Dr. Wyant, if you could take back to the Agency the message which I think is quite clear on behalf of this committee, that at least a 1-year extension, which is supported by both the chairman, Senator Rockefeller and Senator Murkowski, of the vocational training program is going to be approved, and give us an answer back for the record as to what the implications would be for such a 1-year extension in terms of your need for staffing, in line with the testimony that you have given us this morning.

Dr. **Wyant**. We would be glad to.

[Subsequently, the Veterans' Administration furnished the following information:]

The staffing required to accomplish the evaluations and programs of services for veterans during a 1-year extension would impact both 1989 and 1990. The additional FTEE for these years would be 13 and 10 respectively.

Mr. **Steinberg**. Could you describe some of the significant recommendations of the employment services task group, which is made up of some of your field staff, for improving voc rehab services under chapter 31, and tell us what the status is of the implementation of those recommendations?

Dr. **Wyant**. I would be glad to, Mr. Steinberg.

[Subsequently, the Veterans' Administration furnished the following information:]

A group of nine VR&E Service professionals with expertise in vocational rehabilitation and employment placement met on two separate occasions to study problems impeding the effective delivery of employment services to chapter 31 participants. The group responded with a list of 18 recommendations to the 36 problem areas identified. The recommendations clustered in the following areas:

Improving the overall qualification and competencies of the professional staff;
Emphasis on a "team" approach to the vocational rehabilitation process; and
Providing more effective case management methods.

A detailed plan to implement the 18 recommendations is now under development.

Dr. WYANT. As you know, employment services is one area on which we have been putting the highest priority. This was a self-directed, recommended study from within our service, consisting of field people as well as some of our Central Office Personnel.

One of the recommendations that I will mention right upfront—maybe great minds think alike—was in the bill that Chairman Cranston introduced, S. 2307, which would provide for nonpaid on-job training and work experience; and nominally paid job training and work experiences at the State and local government level.

Within the Federal Government there are 2 million jobs; at the State and local level there are an additional 14 million jobs. This would help to give Chapter 31 participants the opportunity to train on the job and gain work experience, and prove to employers that they could do the job. This is one recommendation.

Others had to do with staff training, giving them better job-readiness skills, to teach them job-readiness skills. Another recommendation had to do with teaching job-readiness skills to job applicants. This is an area that we feel is extremely important.

Another is additional outreach to employers and to disabled veterans about possibilities of employment. There were done 30 different recommendations.

Currently we are putting together—and we will be presenting this to our Veterans' Advisory Committee on Rehabilitation, chaired by Ron Drach of the Disabled American Veterans, at our meeting next week—the 18 or so recommendations that we feel we can presently work on with existing resources and without any change in legislation or regulations.

Mr. STEINBERG. Could you please provide to the committee a copy of the task force's report, and provide a written response in more detail describing your implementation plan, such as it may be, for each of those recommendations? And please provide a copy to the minority at the same time that you provide it to us.

Dr. WYANT. We will be glad to. We are quite proud of the work of this task force.

Mr. STEINBERG. Thank you.

[Subsequently, the Veterans' Administration furnished the information which appears on p. 226.]

Mr. STEINBERG. In fiscal year 1986, the number of cases for which an individual vocational and rehabilitation counseling specialist was responsible was 170 cases. And as I indicated earlier, it went up to 181 cases in fiscal 1987. What is it now in fiscal 1988?

Dr. WYANT. To the present, I believe last month it was 194.

Mr. STEINBERG. In light of this increase, which seems to be continuing over the last 2 years, which obviously must affect the timeliness of all chapter 31 services, did the VA ask OMB for an increase in FTE for fiscal year 1987?

Dr. WYANT. I would have to provide that for the record.

Mr. STEINBERG. Would you do that?

Dr. WYANT. Yes, sir.

Mr. Steinberg. Can you tell us whether such an increase was requested for fiscal year 1988?

Dr. Wyant. I will have to provide that for the record.

Mr. Steinberg. How about for fiscal year 1989?

Dr. Wyant. I think, as you presently stated, there is a decrease.

Mr. Steinberg. Well, what I was asking was, the VA's request to OMB.

Dr. Wyant. I will have to find out exactly what happened, the final status of that.

Mr. Steinberg. And as to each of those matters—1987, 1988, and 1989—would you please tell us what DVB's request was within the Agency as well as the Agency request to OMB?

Dr. Wyant. Yes, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

The budget submission to OMB for 1987 requested an increase of 11 FTEE. The submission of 1988 included an increase of 5 FTEE. The 1989 VA budget submission included a decrease of 5 FTEE which was in part the result of reassigning the cost of Central Office VR&E staff from the CP&E program to the VR&E program.

The DVB budget request was a part of the Agency submission for the same years and was a decrease of 22 in 1987, an increase of 5 in 1988, and a decrease of 2 in 1989.

Mr. Steinberg. In your professional judgment as a professional with a doctorate in rehabilitation counseling, can a vocational rehabilitation and counseling specialist provide adequate case management services with a caseload of 181 cases, or, currently, 194 cases?

Dr. Wyant. I think a vocational rehabilitation specialist in that circumstance has to really pick and choose the cases that are in the most need. To provide full services to all that would result in less than 1 hour per participant per month. That is certainly not case management.

We have told our vocational rehabilitation specialists they really have to pick and choose those participants who are in dire need, or in the most need, of rehabilitation case management.

Mr. Steinberg. Do you know how the 194 figure compares to the average caseload for a State VR counselor?

Dr. Wyant. Probably 100 to 110 max—100 on the low end and 110 on the high end in the Federal/State system.

Mr. Steinberg. Thank you.

The American Legion states, on page 14 of its written statement, that "greater coordination with State and Federal employment services, particularly those of the Department of Labor, would help greatly to improve the level of direct service available to veterans in the vocational rehabilitation program." Do you agree with this statement, Dennis?

Dr. Wyant. I think that we can always improve services; however, I feel that our relationship with both the Department of Labor and the rehabilitation services administration, through their Federal/State programs, has improved over the past 3 or 4 years. There are many examples of joint projects. However, these are not uniform throughout the system, but we have a personal commitment to continue to better those relationships.

Just this week we had a very large meeting in the VA on the new Veterans Job Training Act with our colleagues from DM&S and the Labor Department. Our services can always improve further, though.

Mr. STEINBERG. Much of the testimony today points to a great need for expanded training of vocational rehabilitation and counseling staff members, with respect to the skills that they need to carry out chapter 31 effectively, particularly in the area of employment services.

As things stand now under your 1988 and your 1989 budget requests, is such training going to be provided in the near future? Or do you not have sufficient funds for that purpose?

Dr. WYANT. We trained all of our staff in the last fiscal year. During this fiscal year it appears that we will not be doing any training as a group. We do encourage the staff to attend meetings at the local level and the State level through professional organizations, and we do have materials going to the field, hopefully that will help supplement their on-station training, to assist them to become better counseling psychologists and vocational rehabilitation specialists.

Mr. STEINBERG. We were speaking specifically of employment services. Was your answer directed to employment services or just to training in general?

Dr. WYANT. That was training in general, but my emphasis has been on employment services, and I know that you asked about the next fiscal year. A current initiative with the Department of Labor concerns negotiating for the training of some of our vocational rehabilitation specialists, particularly, and maybe some counseling psychologists, at the National Veterans' Training Institute in Denver, which does focus strictly on employment services skills training.

Mr. STEINBERG. That was indeed my next question. We would appreciate it if you could provide for the record the results of those negotiations and the extent to which you are able to enter into agreements with the Department of Labor for the training at the Veterans' Training Services Institute.

And if you would also, please, provide for the record a detailed response on the question of training, both training provided in fiscal years 1987, 1988, and your plan for 1988 and 1989—for employment services, and generally, please.

Dr. WYANT. Yes, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

With the enactment of Public Law 100-323, the Veterans' Employment, Training and Counseling Amendments of 1988, the Secretary of Labor has been authorized to provide training to certain Department of Labor staff at the National Veterans' Employment and Training Services Institute (NVETSI). Additionally, other personnel involved in the provision of employment, job training, counseling, placement, or related services to veterans may be provided the training services through NVETSI.

We have had discussions with staff of the Assistant Secretary for Veterans' Employment and Training and believe, given sufficient funding, that the Department of Labor will allocate a number of training slots to VR&C staff beginning in fiscal year 1989. Travel expenses, training costs, and per diem will be from the Department of Labor appropriations.

FISCAL YEAR 1987

During fiscal year 1987, the VR&E Service conducted training for 420 professional staff at six regional workshops. Training was held in Atlanta, Georgia; Cleveland, Ohio; Los Angeles, California; Manchester, New Hampshire; Denver, Colorado; and Dallas, Texas. Training involved a wide range of subjects related to the rehabilitation process with special emphasis on assessment of rehabilitation potential and the provision of employment services to chapter 31 participants. The employment services part of the workshop provided both didactic presentations and practical exercises.

FISCAL YEAR 1988

A week long workshop of regional office VR&C officers is being planned for Washington, DC in September 1988. This will mark the first time the VR&C Officers have been together as a group for training since January 1985. The workshop will focus on methods of improving the quality of rehabilitation services. Specific topics to be addressed include: VR&C Quality Review System; Productivity Measurement; Result of Work Measurement Study; M28-1, Part III, Rehabilitation Services and Assistance; Recommendations of the Employment Services Task Force; Functional Assessment Rating System, Development of Self Employment Plans; and Implementation of the Program Evaluation System.

FISCAL YEAR 1989

(a) The VR&E Service plans to conduct a week long VR&C Officer training workshop to improve both quality and timeliness.

(b) VR&E Service will initiate a program of staff training using Central Office developed computer assisted instruction (CAI) modules.

(c) Implement centrally directed and funded Counseling Psychologist and Vocational Rehabilitation Specialist training program.

Mr. STEINBERG. Dr. Wyant, about three years ago the VA's education service—I guess it was actually about 2 years ago—was merged into the vocational rehabilitation and counseling service, and you were promoted from heading up the VR service to being Director of the merged vocational rehabilitation and education service. Did you say October of 1986? Is that correct?

Dr. WYANT. Yes, sir.

Mr. STEINBERG. So we are coming up on a 2-year anniversary in 3 or 4 months.

Since the time of that reorganization and the increased authority that you have assumed as a result of it, what have you done to make vocational rehabilitation a greater priority within DVB and within the Agency as a whole?

Dr. WYANT. I don't think there has been any change in priorities, whether I was just Director of vocational rehabilitation or Director of the two. Vocational rehabilitation is a favorite program of mine. I was a participant in it. I worked with vets organizations emphasizing the program and then I had the pleasure and opportunity of having vocational rehabilitation as my sole responsibility. Now, it is a joint responsibility. I have the opportunity to talk to my bosses on many occasions to do priority setting within vocational rehabilitation education services.

The reorganization has enhanced staff expertise in that some of the education staff help with projects in the vocational rehabilitation area.

Quite frankly, I don't think the reorganization has changed priorities.

Mr. STEINBERG. So, your testimony is that the merger of those two services into one service and the appointment as director of the merged service of an individual with really lifelong experience in the vocational rehabilitation field has not increased the emphasis within DVB on the chapter 31 program?

Dr. **Wyant**. I don't think it has increased, no. That was not the purpose for the merger.

Mr. **Steinberg**. As a result of the figures that we reviewed a short time ago, the fiscal year 1987 figures and the fiscal year 1988 figures, could one infer that the merger has indeed decreased the priority?

Dr. **Wyant**. I think that would be drawing a wrong conclusion, from my perspective. I think the timeliness that you are talking about has decreased. We have to work within the Department of Veterans' Benefits, utilizing X number of individuals throughout our department and throughout our regional offices. Quite frankly the regional offices administers programs of loan guaranty, compensation and pension, as well as vocational rehabilitation and education, and I think the regional office directors have done about the best they can in this area.

Mr. **Steinberg**. Dr. Wyant, we want to provide you with an opportunity to respond to the recommendations in the IG audit, and that was a question that we had for you. However, it would appear that that would obviously be done in time sequence after Mr. Morani gives his statement. So we will return to you and give you the opportunity to make any specific comments or rebuttals that you choose.

We do expect Senator Rockefeller back shortly, but before we return to direct testimony, then, I am going to direct a couple of questions to Dr. Winship—unless, Tony, you have any questions for Dr. Wyant that you wish to interject at this point.

Mr. **Principi**. No. I would like to hear your response to this very troubling audit that was recently released by the IG. I think it demonstrates that there are very severe problems within the vocational rehabilitation program.

Mr. **Steinberg**. We are in agreement on that sequence, and we will do that after Mr. Morani presents his testimony. Thank you, Tony.

Dr. Winship, we have some questions regarding the relationship between DM&S and DVB regarding voc rehab programs; and, as well, the temporary vocational training program for nonservice-connected pensioners.

Could you describe how vocational rehabilitation services to disabled veterans are coordinated between VA medical centers and VA regional offices?

Dr. **Winship**. I can provide the statements of our policy for you for the record. We do have policies in place which really call for and I think are followed for collaboration and cooperation between those particularly in case management, and I would be happy to provide those policies for you.

Mr. **Steinberg**. Thank you. And would you, in addition, provide any amplification that you wish to make with respect to those?

[Subsequently, the Veterans' Administration furnished the following information:]

In response to the need to update and clarify DM&S policies and procedures in the Case Management program, DM&S Circular 10-87-81 was published (dated

August 6, 1987) which provided relevant information on the program and instructions on completing an improved annual reporting system. Representatives of DVB were invited to participate in the review of the Circular, prior to publication.

[DM&S Circular 10-87-81 appears on p. 192.]

Mr. STEINBERG. It is the impression of the committee that the degree of compliance that you have just indicated is perhaps not as substantial as it might be, and there is much concern about that in our testimony.

For example, page 7 of the testimony of the Paralyzed Veterans of America this morning stated that the chapter 31 program and the vocational training program are getting very little emphasis by VA medical centers. That is the opinion of the PVA.

The PVA also expresses the view that the evaluations and rehabilitation program are simply not a high priority with VA hospital directors who, according to the PVA, are more concerned with diagnostic related groups and acute care.

Could you comment on these two points?

Dr. WINSHIP. I cannot comment in any specific way, but I will be happy to take that and look into it and supply information for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

DRG's, acute care, long-term care, recruitment and retention of staff are all high-priorities of medical center Directors, and well they should be. This, is no way, diminishes the role of the Case Manager or the Vocational Rehabilitation efforts. While these programs may not demand the high visibility of other programs, they are, for the most part, an acute part of the medical center provision of care. There are of course, areas that can be improved, and we fully intend to address any deficiencies we find or are pointed out to us.

Mr. STEINBERG. What DM&S official in the Central Office is the top official who would have responsibility for coordination between the DVB programs and DM&S's programs, insofar as rehabilitation is concerned?

Dr. WINSHIP. Well, ultimately I would be that top programmatic official, because I am in charge of all programs and operations.

Mr. STEINBERG. You seem somewhat either reluctant to discuss this or unable to discuss it this morning.

Dr. WINSHIP. I am unable to discuss it in detail this morning. I have not had the opportunity to review the PVA statement.

Mr. STEINBERG. But you are the top official responsible for that?

Dr. WINSHIP. Yes.

Mr. STEINBERG. Who, next under you, would be the official responsible for that?

Dr. WINSHIP. I would have to check our organizational chart and determine that, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

The Assistant Chief Medical Director for Clinical Affairs is the next DM&S official below the Assistant Deputy Chief Medical Director for Programs and Operations having responsibilities for DM&S rehabilitation medicine programs.

Mr. STEINBERG. If I may just complete this for one moment, Senator Rockefeller?

Senator ROCKEFELLER. Yes, go right ahead.

Mr. **Steinberg**. I must say, that is slightly troubling. We are here discussing the VA's program of vocational rehabilitation. We clearly made known to the Agency that we were concerned about the relationship between DVB and DM&S. You are the top official of the Department of Medicine and Surgery, according to your testimony with respect to that coordination. You can't tell us anything about that coordination, other than that you will give us copies of the circulars, and you are unaware of who under you is the top official in the Agency who is directly responsible for that coordination.

That would suggest to most disinterested observers that indeed the statement of the Paralyzed Veterans of America that very little emphasis is given to this is indeed correct.

Dr. **Winship**. Be that as it may, I will be happy to review the PVA statement and provide that information for you, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

The Case Management program is under the auspices of the Office of Clinical Affairs and located in the Rehabilitation Medicine Service. While coordination between the two Departments is on an "as-needed" basis, efforts to communicate have been made readily and easily available. DVB officials were asked to attend a Case Management briefing in the Office of Clinical Affairs and assisted in the review/concurrences of the recent DM&S Circular on Case Management (Circular 10-87-81). In addition, DM&S officials were asked (and complied) to review and comment on a recent DVB Manual update which included DVB Case Management directives.

Mr. **Steinberg**. Do you have a view, Dr. Winship, on whether or not the VA's resource allocation methodology provides for an appropriate emphasis on the needs of chapter 31 participants whose care would appear to be largely in the area of rehabilitation medicine?

Dr. **Winship**. I think that our group that has been looking at the resource allocation methodology of late has been focusing considerable attention on the rehabilitation portion of our medical care because of some concerns that there may not be equity in that sort of allocation, and I believe that some changes in that will be forthcoming.

Mr. **Steinberg**. Could you provide us with a more specific written response on that issue, and of the changes that are under consideration?

Dr. **Winship**. Yes, I could.

Mr. **Steinberg**. And when such changes are made, would you make sure that the committee is notified?

Dr. **Winship**. Yes, sir.

Mr. **Steinberg**. Or if the decision is made not to make them, that we are notified of that as well, please?

Dr. **Winship**. Yes, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

When the acute care Resource Allocation Methodology (RAM) was implemented in fiscal year 1985, it was agreed that chronic care, including rehabilitation, might be at a resource allocation disadvantage, but that length-of-stay incentives were appropriate for most of that care. Therefore, rehabilitation medicine workloads were retained in the acute care RAM. However, it was also agreed that the Department should (1) work to define the nature of rahabilitation to allow RAM to more adequately fund rehabilitation care, and (2) explore interim fixes to the RAM to make it more sensitive to rehabilitation costs and workloads.

In fiscal year 1986 the outpatient RAM was modified to add a capitation group for patients receiving multiple rehabilitation treatments in medical center outpatient departments. In recent years, VA medical centers have responded to the acute care RAM by shortening lengths of stay for rehabilitation patients and coding more rehabilitation discharges in the rehabilitation DRG (#462). This DRG provides better funding than did some of the DRGs previously assigned to rehabilitation discharges.

Some VA medical centers operate a Comprehensive Rehabilitation Center (CRC) which provides intensive rehabilitation services. Since the DRG for rehabilitation does not recognize the intensity of care associated with the CRC, the resources specifically provided by VACO for the CRC have been exempted from the RAM process. This policy has been in effect since about fiscal year 1986.

In the Resource Utilization Group (RUG) resource allocation methodology used for Long Term Care, rehabilitation is the highest value category of care. Prior to October 1986, a patient had to have five sessions a week of either occupational or physical therapy to be included in the rehabilitation category. Beginning in October 1986, corrective therapy, education, and manual arts were added to the list of qualifying rehabilitation modalities, thus increasing the number of patients qualifying for the highest category under RUGs.

During the past 15 months, the Chief Medical Director's RAM Task Force has considered several proposals for modifying the RAM for rehabilitation patients. One proposal was to provide higher funding for DRG outlier days and census days. Another was to provide more high outlier funding for the DRGs that accounted for the bulk of the rehabilitation workload. These two proposals were preliminary and received modest debate because the priorities of the Task Force were focused on RAM characteristics that impacted on a broader spectrum of patients and VA facilities. The RAM Task Force will return to the issue of funding rehabilitation in the VA during the next several months and will make specific recommendations to the Chief Medical Director.

Mr. STEINBERG. A final recommendation of the PVA on page 9 is that "the Administrator must take action to enable the chapter 31 program to be delivered by a cohesive and united team, one with identical objectives, and one that can prioritize vocational rehabilitation within the spectrum of all benefit programs and medical activities."

Would you comment on that, Dr. Wyant?

Dr. WYANT. Well, we believe that, with our case management concept, our case manager would take the lead on this, in most cases. Sometimes it would be Dr. Winship's people, and other times it would be Dr. Errera's people.

Our staffs have good relationships at each of these different medical facilities. And quite frankly, the kind of complaints that I get through my office, usually from veterans, are on timeliness and very seldom on quality of service in the DM&S system.

Mr. STEINBERG. Is coordination with DM&S one of your responsibilities?

Dr. WYANT. Yes, sir, it is.

Mr. STEINBERG. Would you tell us with whom you seek to coordinate in DM&S?

Dr. WYANT. Usually I do it at the two levels below Dr. Winship. I have considerable coordination with Fred Downs, Director of Prosthetics, Don Garner, Director of Blind Rehabilitation, and with Dr. Errera's staff at different levels, depending on the program. Much of our coordination with medical administration service is in the area of veterans needing eyeglasses. Eyeglasses are something that you need quickly and not 8 or 9 weeks into the semester.

So these are the primary coordinators within Central Office. Our chiefs of VR&C at the regional office level and their case managers have their own contacts at the different facilities.

Mr. STEINBERG. Is there any guidance that you issue with respect to establishing such contacts?

Dr. WYANT. Yes, there is.

Mr. STEINBERG. Could you provide that for the record, please?

Dr. WYANT. We would be glad to.

[Subsequently, the Veterans' Administration furnished the following information:]

The Chief Benefits Director issued instructions in the form of changes to the VR&C manual of procedures (M28-1) in 1982, which provided guidance on establishing and maintaining contracts and coordination of services for veterans in the chapter 31 program. This was followed up by the Deputy Chief Medical Director in 1983, and is now part of the VR&C manual of procedures issued to field staff in 1987 (M28-1, Part I, Chapter 2). In August 1987, the Department of Medicine and Surgery issued Circular 10-87-81 to establish policies and procedures for a case management program which emphasizes vocational rehabilitation services and to revise the annual reporting system (RCS 10-0109). Therefore, both DVB and DM&S have provided revised and updated instructions to their respective field staffs during the past year.

Mr. STEINBERG. Dr. Winship, would you please, for the record, provide your views, the Department's views, with respect to the observation by the Paralyzed Veterans of the need for a cohesive and united approach with identical objectives and identical priorities with respect to coordination between DM&S and DVB?

Dr. WINSHIP. Yes, we will.

Mr. STEINBERG. Again, that was on page 9 of their written testimony.

[Subsequently, the Veterans' Administration furnished the following information:]

We concur with the sentiments of the Paralyzed Veterans of America.

Mr. STEINBERG. At this point we will ask you, Dr. Wyant, if you are prepared, to proceed with the summary of your statement, and then we will go to Mr. Morani.

Dr. WYANT. Five minutes?

Mr. STEINBERG. Yes; the testimony that we deferred somewhat.

Dr. WYANT. OK, fine.

Mr. STEINBERG. And again, our apologies for going out of order.

STATEMENT OF DR. DENNIS R. WYANT, DIRECTOR, VOCATIONAL REHABILITATION AND EDUCATION SERVICE, DEPARTMENT OF VETERANS' BENEFITS, VETERANS' ADMINISTRATION, ACCOMPANIED BY JAMES REED, ASSISTANT DIRECTOR FOR VOCATIONAL REHABILITATION AND COUNSELING

Dr. WYANT. Today testifying, as we have answered many questions already, you do have our complete statement, and we would like to have that submitted for the record.

Mr. STEINBERG. It will be.

Dr. WYANT. My short testimony here will even be shorter than I had originally planned, because I think we have already covered much of it.

Mr. STEINBERG. Thank you.

Dr. WYANT. We are in 58 regional offices, 44 outbased locations. I have a staff of 274 counseling psychologists, 150 voc rehab specialists, as well as a field support staff and a small support staff in Central Office.

During a year's time we will do 40,000 chapter 31 evaluations and an additional 3,500 chapter 15 or vocational training evaluations.

Of those chapter 31 evaluations, we will have an entitlement rate or find about 70 percent eligible for services. We will have around 25,000 people in a training program at any one time. This number has stayed consistent for the past 3 or 4 years. There is just a slight decrease.

And we must say that Public Law 96-466, which this committee did so much work on, and really brought the rehabilitation program in the VA out of the forties and fifties into the eighties, has provided a very comprehensive approach toward rehabilitation. Through individual written rehabilitation plans, we provide employment services to some 4,000 veterans. About 65 percent of those folks go to work each year.

In the area of the vocational training program for pensioners, we have found that has been an exciting pilot program over the past 3 years, and you will be receiving our report on that program in the near future.

In addition, we do provide counseling services under chapter 30, title 38, United States Code, a part of the New Montgomery GI Bill, under chapter 106, title 10, United States Code, another part of the Montgomery GI Bill, the Old GI Bill (chapter 34) under chapter 35 for dependents and spouses, and the VEAP Program (chapter 32), which, when added to the Pension Pilot Program (under chapter 15), is about 10,000 additional counseling cases each year. We also provide job counseling under the Veterans' Job Training Act, VJTA.

As I have mentioned in answering some of the questions, my highest priority since I have been in this service has been to improve employment services as part of the vocational rehabilitation program created by Public Law 96-466. The Employment Task Force that we talked about is part of this emphasis.

Other high priorities: We have already talked about the chapter 31 target system, getting that payment system on, which will provide more timely payments to veterans and will help eliminate overpayments and errors.

Two other areas: One, as you mentioned, is the computer assisted instruction system. We feel that is a dynamite system, and we are anxious to get that throughout all of our regional offices and outbased locations, because we can do computerized testing. It has guidance information systems on it; it has a job bank.

Another one of the systems I am extremely interested in is called a "functional assessment system." This is so critical in the field of rehabilitation, because it cannot only have us look at the abilities and the disabilities of an individual but also give us a program of action on how to best provide services to this disabled veteran.

One of the programs we are introducing—in all of these initiatives we are seeking to improve quality—is a new quality review system, much of which came from California, specifically our San Diego project. It will provide us a system for helping to train our field staff while we judge their quality. It is not just a "right" or "wrong" system. Our old system only pointed out the negative, when something was incorrect. This system will actually give a quality rating and provide a training tool to continue improving the quality of our services.

So, with that short summary, I would be glad to continue to answer questions or to listen to our friends from the IG office talk about our vocational rehabilitation audit.

Mr. STEINBERG. Thank you very much, Dennis.

[The prepared statement of Dr. Wyant appears on p. 215.]

Mr. STEINBERG. Let me indicate a factor that has arisen with respect to our plans for Senator Rockefeller's being able to chair the hearing.

A meeting of the Finance Committee has been scheduled at the very last minute to consider the Welfare Reform bill, which some of you may know is the pending business in the Senate, and on which there have been extensive negotiations over the past several days between the Finance Committee leadership and the White House.

Unfortunately, Senator Rockefeller is going to have to attend that meeting momentarily since he was a major participant in the shaping of the Welfare Reform proposal which came out of the Finance Committee.

So, our apologies to this panel and to all of our witnesses, to the extent that Senator Rockefeller is deflected from being here with us as a result not only of the rollcall vote we had earlier, which, of course, we can't predict, but the scheduling of this urgent Finance Committee session.

Now we would like to turn to Mr. Morani, the Acting Inspector General of the Veterans' Administration.

Would you please summarize for us, in 5 minutes, the result of your audit?

STATEMENT OF RENALD P. MORANI, ACTING INSPECTOR GENERAL, VETERANS' ADMINISTRATION, ACCOMPANIED BY KENNETH FURUKAWA, ASSISTANT INSPECTOR GENERAL FOR AUDITING; AND JOHN MECHE, AUDIT MANAGER

Mr. MORANI. Thank you, Mr. Steinberg. Yes, I will.

I am pleased to be here today to discuss our recent audit of the VA's vocational rehabilitation program.

A quick summary of the audit is as follows:

The vocational rehabilitation program was established to provide services and assistance necessary to enable veterans who have service-connected disabilities that materially contribute to an employment handicap to become employable and obtain and retain suitable employment.

About 27,000 veterans participate in the program, and the current annual program costs are $125 million. The program provides payments for tuition, fees, books, subsistence and other expenses, and is administered by a staff of about 560 employees in VA Central Office and 57 regional offices.

The audit was made to determine whether its intended purpose of rehabilitating veterans was being accomplished in an effective and economic manner.

The audit included reviews of eligibility determinations, selections for specific training programs, accuracy of reported program success rate, and the appropriateness of employment adjustment allowance payments.

The audit disclosed that counseling psychologists did not clearly establish during eligibility determinations that many veterans had existing employment handicaps and that their service-connected disabilities materially contributed to these employment handicaps.

In some cases the training programs that were selected for the veterans were incompatible with their disabilities or inconsistent with their interests, aptitudes and abilities.

We also found that the reported rate of success for the program was overstated. Our analysis showed that only 6 percent instead of 12.6 percent of the 27,000 participating veterans were considered rehabilitated. Some veterans should not have been reported as rehabilitated, because they did not obtain suitable employment consistent with their training, they did not need rehabilitative training, they did not obtain and retain jobs for 60 days, or they received no training or services.

Lastly, our audit showed that payments of employment adjustment allowances were made to veterans who did not complete an approved training program, or who were employed before completing rehabilitation training.

In this audit, we made 12 recommendations to the Chief Benefits Director to establish new policies and internal control procedures which would reduce program costs and would result in more effective accomplishment of program objectives.

The Chief Benefits Director concurred with 11 of the 12 recommendations and provided acceptable implementation plans for these audit recommendations.

Although the Chief Benefits Director disagreed with the recommendation concerning payment of employment adjustment allowances, he stated that the program staff are examining payment of allowances, and that this examination will likely result in adjustment of policy and probably recommendations for legislative or regulatory change in this area.

This is an acceptable approach, and we will review the examination results before closing out this issue.

I believe it is also worth mentioning that during the audit, as interim results became known, program staff initiated several immediate actions to improve the program.

That concludes my statement, Mr. Chairman. We will be pleased to respond to any questions that you may have.

Senator ROCKEFELLER. Thank you very much.

Mr. MORANI. Thank you.

Senator ROCKEFELLER. To start with, on page 2 of your March 21, 1988, the audit report states that your work included a review of 130 veterans' records randomly selected by way of statistical sampling techniques to determine whether veterans enrolled in the program met established eligibility criteria and were placed in training consistent with their abilities, aptitudes and interests.

Are you confident that you can, in a statistically valid manner, generalize the findings from these 130 veterans to all veterans enrolled in the vocational rehabilitation program at the time of the sample?

Mr. **Morani**. Sir, the answer to that question takes on several different aspects. To the extent that surveys or preliminary work indicate consistency of application of a standard criteria, we feel very confident.

From the standpoint of these tests, we found that the prescribed criteria would be sufficient to make that judgment, and was sufficient to make that judgment, if followed consistently and uniformly throughout the VA organization.

Senator **Rockefeller**. That was out of a sample of a total of how many? How many could have been sampled as opposed to how many were?

Mr. **Morani**. Twenty-seven thousand was the base, Senator Rockefeller, and we sampled 130 from the total universe.

Senator **Rockefeller**. That is a reliable sample?

Mr. **Morani**. Yes, sir. To the extent that the criteria was prescribed to be followed in a uniform manner—in other words, that local option was not permitted to various regional offices—we feel that that sample is a reliable indicator of the implementation of that criteria. Yes, sir.

Senator **Rockefeller**. OK.

One of the major recommendations of your audit is that the Chief Benefits Director needs to establish internal control procedures to ensure that (a) veterans who participate in the chapter 31 program are actually eligible, (b) the success rate of rehabilitation is accurately measured, and (c) employment adjustment allowances are properly administered.

To what extent, if any, do you believe that the deficiencies you found in the administration of the program are attributable to reductions in FTEE for the vocational rehabilitation program over the past several years?

Mr. **Morani**. To be quite candid, I don't believe our finding related to the cost to that extent, Senator. What the finding related to specifically is in the area of criteria implementation and the deficiencies that we found in applying that criteria.

Also, it could very well be related to a number of other issues, as to the lack of personnel or lack of training or lack of understanding that existed from office to office and from case to case. But we could not and did not tie it down to a lack of available personnel or FTE or increased caseloads, or other issues that I think you are looking for there.

Senator **Rockefeller**. Is the need for tighter administrative controls a managerial issue or a staffing issue?

Mr. **Morani**. Well, I believe the need for managerial controls is a policy issue that should be addressed—along with the criteria—spelling out precisely the requirements of eligibility and the assurance that the eligibility requirements in the deliberations and the reviews of each case are implemented as prescribed. From a policy standpoint, I believe it is a managerial issue.

Senator **Rockefeller**. Dr. Wyant, do you agree with those responses?

Dr. **Wyant**. The recommendations in the IG report that you have read on how to improve are something that we all agreed to inhouse, basically. Most of the recommendations involve concerns that we are continuously working on, and they do have to do with management from my level down to the field. So, we don't disagree with that aspect of the study.

Senator ROCKEFELLER. Thank you.

Mr. Morani, with respect to employment adjustment allowance for payments, or allowance payments, your audit recommended that the Chief Benefits Director issue specific policy directives to preclude routine payment of employment adjustment allowances to veterans who do not complete their approved training program, or who were employed in the same job during training.

Do you have specific data in terms of your findings to back up the recommendation?

Mr. MORANI. Yes, sir, I believe we do. There was a question as to the legitimate entitlements from an interpretation of the eligibility criteria. The disagreement centers around the recommendation that the Chief Benefits Director felt was too restrictive; because I am told there are cases where, in the opinion of program managers, the employability factor has been resolved with the individual, yet the course was not being completed. I think that degree of flexibility is reasonable.

Dr. WYANT. Mr. Chairman, may I make a comment?

Senator ROCKEFELLER. Yes, Dr. Wyant.

Dr. WYANT. Thank you.

We would like to point out that there was not a single instance in which the IG found that we paid an employment allowance in violation of the law. It was paid, in every situation, consistent with the regulations and law as written. I just wanted to make sure that that was shown on the record. They disagree with the law, not our procedure.

Senator ROCKEFELLER. I understand.

When you refer to data that you do have, can that be made available to the committee?

Mr. MORANI. Yes, sir, we can provide you the excerpts of our evaluations and the working papers or the supporting evidence to support this conclusion.

Senator ROCKEFELLER. Thank you, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

As part of the Office of Inspector General review of the VA's Vocational Rehabilitation Program, we reviewed the appropriateness of employment adjustment allowance payments to veterans. The audit identified inappropriate payments, in our opinion, to 16 of the 72 veterans reviewed. Two issues are involved in these 16 cases and are discussed separately in the following paragraphs.

Veterans did not complete their training program

Seven of the sixteen veterans who were paid the allowance did not complete their training program and should not have received the allowance. The law, 38 U.S.C. § 1508(a)(2) specifically states that:

> In any case in which the Administrator determines, at the conclusion of such veteran's pursuit of a vocational rehabilitation program under this chapter, that such veteran has been rehabilitated to the point of employability, such veteran shall be paid a subsistence allowance . . . for 2 months following the conclusion of such pursuit.

(Emphasis added) The law defines the term "rehabilitated to the point of employability" as meaning ". . . employable in an occupation for which a vocational rehabilitation program has been provided under this chapter." The details of the seven cases are:

Case No. 1—The veteran was approved for a 24-month machinist course at a vocational school. He dropped out after 7 months when he obtained employment on his own. Program officials in VA Central Office agreed that the payment of the employment adjustment allowance was inappropriate.

Case No. 2—The veteran was approved for a degree program in accounting. Although he attended college for 6 years, the veteran did not obtain a degree. During training, he obtained employment as a postal clerk. He dropped out of college when eligibility for VA subsistence expired. Since the veteran did not complete his pursuit of the vocational rehabilitation program and was employed in a job unrelated to his training, local officials should not have reported the veteran as rehabilitated and should not have paid the allowance. Program officials did not comment on the appropriateness of the allowance payment, but they agreed that the veteran should not have been determined rehabilitated.

Case No. 3—This veteran was approved for 6 months training to complete the degree program that he had pursued for 39 months under another VA program (chapter 34). The documentation in the file was poor, and there was no evidence that the veteran completed training. It appeared that the veteran dropped out of college when his eligibility for benefits expired. He obtained temporary employment with a construction company. Since there was no evidence that the veteran graduated from college and he was employed in a job unrelated to his training, local officials should not have reported the veteran as rehabilitated and should not have paid the employment adjustment allowance. Program officials did not comment on the appropriateness of the allowance payment, but they agreed that rehabilitation cannot be justified on the documented evidence.

Case No. 4—The veteran retired from the military after 20 years as an electronics technician. He was approved for a 4-year degree program in Sociology. He attended college part-time from 1977 to 1985. He dropped out when his eligibility for VA benefits expired. Local officials declared the veteran rehabilitated because he was employed full-time as an instrument checker and paid the employment adjustment allowance. Since the veteran did not complete his pursuit of the vocational rehabilitation program and was employed in a job unrelated to his training, payment of the employment adjustment allowance was inappropriate. Program officials did not comment on the appropriateness of the allowance payment, but they agreed that the veteran did not obtain employment consistent with the objectives of his rehabilitation program.

Case No. 5—The veteran was approved for a 2-year associate degree in computer programming. He attended school for 2 years, but dropped out without completing requirements for an associate degree. Local officials reported the veteran as rehabilitated when they discovered he was employed in a plastics factory. Since the veteran did not complete his pursuit of the vocational rehabilitation program and was employed in a job unrelated to his training, payment of the employment adjustment allowance was inappropriate. Program officials did not comment on the appropriateness of the allowance payment, but they agreed that placement of the veteran ". . . in rehabilitated status in an occupation which is contraindicated by disability is inappropriate."

Case No. 6—The veteran was approved for a 2-year program to become a chef. Although records showed that he attended training for about 2 years, the files did not include evidence that the veteran completed the course and graduated. The allowance should not have been authorized without proper documentation. Program officials did not comment on the appropriateness of the allowance payment, but they agreed that ". . . there is no documentation in the record to support VR&C's contention that this veteran has achieved rehabilitated status."

Case No. 7—This veteran pursued his training objective for only 3 months and dropped out without notifying the VA. During a routine followup, the veteran told local officials that he had obtained employment on his own as a data entry clerk. Local officials authorized payment of the employment adjustment allowance about 9 months after the veteran dropped out retroactively effective on the date that the veteran might have completed his approved training program. Program officials did not review the appropriateness of the payment of the employment adjustment allowance for this veteran.

Veterans were already employed long before employment adjustment allowances were authorized

Nine veterans completed their approved vocational training program and were paid an employment adjustment allowance in accordance with a strict interpretation of the law. However, the audit disclosed that these veterans were working for the same employer prior to beginning training or had been working full-time for an average of 16 months before completing their training programs.

> In our opinion, the drafters of the law could not have envisioned that participants, who were completing their approved programs and receiving a 2-month employment adjustment allowance as an aid in the transition into the work environment, had been working full-time for the same employer for up to 10 years. Details follow:
>
> Four veterans were employed by the same employer before, during, and after training.
>
> Five veterans obtained full-time employment during training. They were employed for up to 3½ years, with an average time of employment being 16 months prior to completion of their training program. For example, one veteran worked full-time as a mechanic for 18 months prior to completing his 2-year program in auto mechanics. Another veteran worked full-time as a postal carrier prior to completing his associate degree in computer programming.
>
> In commenting on these cases, program officials stated "The 2-month rehabilitation award is not a discretionary payment and all veterans completing training are entitled to it."
>
> We believe that the allowance was intended for veterans who complete their approved training program and are pursuing employment in an occupation for which training was provided under a vocational rehabilitation program.

Senator ROCKEFELLER. Dr. Wyant, I believe the Chief Benefits Director disagreed with the IG's recommendation regarding employment adjustment assistance payments. What is the basis for the disagreement?

Dr. WYANT. Basically that we are following the law and the regulations that were written to implement the law, and some of their recommendations saying, for example, if the law were even to be changed———

Senator ROCKEFELLER. Would you repeat what you just said about the law being changed?

Dr. WYANT. I said, for example in their proposal, if they were proposing that the law would be changed so that we don't pay it to a person who takes an on-the-job training program, I doubt, within the Department, that we could agree with that. We would see that as a negative incentive because the person would not take a job until he or she completed a training program.

So, we just felt, first, that we were following the law, and, second, that their recommendations were not in the best interest of disabled veterans.

Senator ROCKEFELLER. And you would oppose the idea of changing the law?

Dr. WYANT. That is my own personal opinion; but that would eventually have to be the Administrator's decision, based on input from the Inspector General, and our office. We would certainly be supplying a lot of information, I think justifying why the veteran needs those couple of months subsistence allowance to hold him over until he gets into the workforce.

Senator ROCKEFELLER. OK.

The Chief Benefits Director's December 21, 1987, memorandum to the inspector general providing comments on the draft report of audit on the vocational rehabilitation program stated that,

> We have been able to concur in 11 out of the 12 recommendations, but we do take issue with the supporting statements, statistics, interpretation of laws, regulations, and program policies that exist in the text.

In addition, the Chief Benefits Director states that he "does not concur that the nature and degree of concerns exist at the level indicated by the audit staff."

Mr. Morani, what is your reaction to those comments?

Mr. **Morani**. Well, we recognize those statements, and I think it is a matter of degree. We respect the opinions of the Chief Benefits Director on that point, and we had extensive meetings and discussions regarding interpretation, Senator Rockefeller.

From a programmatic point of view, DVB may view it more liberally as to whether it satisfies the intent of the law or the intent of the policy. We are looking at it more from the standpoint of:

> Are fiscal interests being protected? Are there sufficient internal controls in place to prevent the misappropriation of funds or the entitlement of individuals that are not justified?

So, it is in that area of interpretation that we have had a lot of discussions, and the program people feel that the specifics that we describe in the report may not, in their judgment, reflect the degree of the problem. Now, this degree can range from 25 percent, which in our opinion could be significant in terms of dollars, up to 80 percent. We don't try to characterize that degree as much as emphasize that corrective actions are necessary from the point of view of improving the effectiveness of operations.

Once we receive concurrence on something that needs to be corrected, I don't think we should dwell on degree and debate that issue out. I think there is a justifiable difference of opinion at times, and we work within that give and take.

Senator **Rockefeller**. OK.

What system do you have for monitoring the implementation by the Chief Benefits Director of the 11 recommendations made in the audit?

Mr. **Morani**. We have an ongoing followup system which periodically will address the implementing instructions. We will followup on the new instructions or circulars or policies stated in the concurrence comments that we receive, to see that due dates are met and that policy and procedures are issued. That process follows within 3 to 6 months of the audit.

We also have a periodic review of major programmatic areas every 2 years, where we go in on a separate followup with an audit team to reassess the degree of corrective actions that this program has sustained or has not sustained. We report our findings to the Deputy Administrator as part of the followup procedure. He is the designated followup official for the VA.

Senator **Rockefeller**. Dr. Wyant, what methods would you employ to ensure that these recommendations are properly implemented at VA regional offices?

Dr. **Wyant**. Mr. Chairman, many of these concerns that you see as recommendations from the IG were already projects that we were working on and already had systems partially in place to monitor.

Of course, when a study like this is done, as the Inspector General's office has said, it does make us focus more attention at that moment on that. We have not only done followup on their recommendations, but have our own individual studies going on at the same time, as was mentioned in the testimony.

It is certainly our interest to improve the quality of service to the veteran and, as we said, to be as fiscally responsible and economical as possible, but not at the expense of hurting the rehabilitation of disabled veterans, as we made clear several times throughout the audit.

Again, we feel very committed that none of these things should be done at the expense of the disabled veteran.

Senator **Rockefeller**. Dr. Wyant, as Mr. Steinberg earlier indicated, I guess, we would like to give you an opportunity to respond to the IG audit in general or in a very specific manner. Do you care to do that, either now or in writing?

Dr. **Wyant**. Mr. Chairman, I will just make a couple of oral comments.

Of course, the IG recommendations are very generic; they are in areas that we do want to try to improve on; they include projects that we were working on prior to the audit and continue to work on now. We will continue to work on them after the audit. As was stated, there is error in such figures as the 6 percent rehabilitation rate, when they compare rehabilitants to the full 27,000 in the program. This was pointed out to the IG's office at least six or seven different times; this is comparing apples to oranges. They ignored us on this.

We asked the IG's office when they did this audit, on a number of occasions, to look at the quality of service as it had to do with staffing and case management; on how much case management, and the span of control over x number of cases. Would we provide better rehabilitation or not? Again, they ignored us on this issue.

We offered to provide training. We were ignored on this issue. Quite frankly, even though we do agree with the recommendations, we wouldn't have needed an IG audit—we could have done that ourselves—it was a very redundant report.

Senator **Rockefeller**. Dr. Reed, did you have anything that you wanted to offer in addition to that?

Dr. **Reed**. No, sir. I think it has been covered.

Senator **Rockefeller**. OK.

Dr. **Wyant**. I will reiterate one statement. In every case that they found, we never erred in denying a veteran benefits that he earned. In every situation that was pointed out, we never ever denied a disabled veteran what he earned. I would just like to emphasize that.

Senator **Rockefeller**. I thank you for being here to testify. And Dr. Wyant, I should say to you that Senator Cranston will be submitting a variety of written questions to you in response to issues raised by the veterans 'service organizations in their written statements.

He would appreciate being able to get your response by June 22, which is fairly quickly.

Dr. **Wyant**. Yes, sir.

Senator **Rockefeller**. Thank you very, very much.

Dr. **Wyant**. Thank you.

Senator **Rockefeller**. I now call Dr. M.J. Willard. Dr. Willard, a psychologist in the Department of Rehabilitation Medicine at Boston University School of Medicine, conducts research on the training of capuchin monkeys as aids to quadriplegics. Dr. Willard is a committed and devoted advocate for improving the quality of life for quadriplegics, and we are glad to have her here with us today.

Dr. Willard, you seem to be our only witness here. So, would you be able to summarize your testimony, in that it will all be in the record, in approximately 5 minutes?

Dr. Willard. Yes.

STATEMENT OF DR. MARY JOAN WILLARD, DIRECTOR, HELPING HANDS: SIMIAN AIDES FOR THE DISABLED, INC.

Dr. Willard. Mr. Chairman and members, I would like to thank you first of all for the opportunity to present my views today on S. 2207, introduced by Senator Murkowski, and S. 2511, introduced by Senator Cranston. I will summarize my statement as I understand it will be presented in entirety for the record.

First of all, quadriplegics require an enormous amount of care. This care is most labor-intensive during the morning and the evening, when you have a routine which involves things such as feeding, dressing, bowel and bladder care, bathing, and transfers into and out of an electric wheelchair.

Once a quadriplegic is up in his electric wheelchair, he can do a variety of activities with a fair degree of independence. For example, he can work with a computer, he can read, study, watch television, listen to music, use the telephone. And he can do these activities with only occasional assistance.

One of the problems is that to provide even intermittent assistance means that someone must be home all day, to provide the assistance when it is needed.

Capuchin monkeys, which are better known sometimes as the "organ-grinder monkey," have been trained to do a variety of simple manual tasks for a quadriplegic for a period of 4 to 8 hours a day.

For example, a quadriplegic uses a mouth stick to turn the pages of a book, to use a computer, to type or dial a telephone. If they drop this really critical instrument, the monkey is trained to simply pick it up and put the correct end back in their mouth.

The electric wheelchair is equipped with a small laser pointer, and the quadriplegic, by manipulating a 1-inch stick in front of his mouth, can direct the laser to point at anything in the room. The laser beam on a book means that the monkey is to transfer that book to the reading stand. A laser beam on a cassette means put it into the tape recorder. On a VHS cassette, it means put it into the VCR recorder.

Senator Rockefeller. Dr. Willard, excuse me for interrupting, but the laser thing, is that visible to the monkey?

Dr. Willard. Yes, it is.

Senator Rockefeller. In other words, what it touches. There is a little circle, and the monkey then——

Dr. Willard. That is right. It is a bright red beam of light.

Senator Rockefeller. Yes.

Dr. Willard. If the quadriplegic points to the refrigerator, the monkey knows to open it. If he then points to a particular container of juice—and these are prepackaged drinks—the monkey will transfer it to a feeding tray, open the juice bottle, and insert a straw.

It is the same thing with respect to sandwiches, which are all cased in plastic containers, which can be transferred to a microwave oven and then to a feeding tray.

These are some of the most basic tasks, and there are at least a dozen others that monkeys have been trained to do, and these tasks were chosen because they were optimally useful for a quadriplegic.

Senator **Rockefeller**. I didn't know this. I mean, it is tremendously exciting.

Dr. **Willard**. I am excited about it, too.

The reliability is a good 90 percent. Again, this is meant to provide a supplement to the human assistance that these quadriplegic veterans already will have.

I am delighted that both Senator Murkowski and Senator Cranston have introduced legislation that will in effect give these service-connected quadriplegic veterans a choice. It gives them the option of using animal assistance.

Bills S. 2511 and S. 2507 are very similar. They have a few different features, but what is critically important to me is that they do provide the necessary authorization so that we can proceed to actually implement these research results.

I do have a concern about the immediate state of VA funding that I just want to mention.

We have submitted a proposal to the VA Research and Development Department requesting up to 18 months of funding. This proposal is both a request for an evaluation and a request to allow us to complete some development work. This development work includes a variety of instructional videotapes as well as a placement manual, and we need these materials to be developed so we can produce monkeys on a larger scale. It just makes it more effective for us to accomplish the long-term goals.

I don't care whether the support comes from research or clinical care moneys; I am just concerned that this not fall between the cracks of the two different programs.

Finally, I would like to close in thanking Senator Cranston and Senator Murkowski for introducing these bills. I would also like to mention my appreciation for PVA, which was the first organization to take a chance on what looked like a rather bizarre proposal back in 1979; and the Veterans' Administration which has been funding this program for the past 6 years and which has enabled us to bring it to this point of implementation.

[The prepared statement of Dr. Willard appears on p. 235.]

Senator **Rockefeller**. I really thank you. And I can understand that first reaction; but I can much more clearly understand what you are saying, that it is an enormously useful way of helping somebody who needs that kind of help. I mean, it is an extraordinary accomplishment.

Where was the original work on this done?

Dr. **Willard**. At the Tufts Medical Center.

Senator **Rockefeller**. And why was it started? What was the first reason?

Dr. **Willard**. I was doing a post-doctoral program, and I met a quadriplegic who was in the hospital, and I was visiting him every day. I found that I was doing these simple tasks for him, because the nurses were there for the critical things but no one is going to hang around all day.

I was also working part-time for B.F. Skinner, who has done a great deal of animal research.

It just dawned on me that these things were so simple and repetitive, and this individual was going to go home and live in his mother's apartment for the rest of his life, and he was going to need these tasks 30 or 40 times a day.

I just thought an animal would be there all the time, and on call.

Senator ROCKEFELLER. That is terrific, just terrific.

In your written statement, you state that, based upon preliminary cost assessments for the placement of 50 animals per year, the cost per placement is $11,770. When do you anticipate your program would be capable of placing 50 animals a year?

Dr. WILLARD. That will probably take us about 5 years to build up to that level.

Senator ROCKEFELLER. Training, I understand, is about a $21,000 cost?

Dr. WILLARD. No. Really, it varies, depending on how many animals you are putting out in a given year. Initially, in the next 12 months, we will only be making six placements. The numbers will go up each year. The following year we will be capable of placing in the neighborhood of 14, and then 19 the year after, and moving up from there.

As the numbers go up, the cost drops. It is just that we need to pay for a training facility and an essential core staff, which you have to maintain whether you are placing 6 monkeys or whether you are placing 25.

It is quite possible that 5 years from now, when we are placing 50 a year—in fact, we hope this to be the case—that the cost would actually drop below this $11,000. And that is because we are looking at the model of the guide-dog programs. There are nine guide-dog schools in this country, and they have been so successful in raising private contributions that there is not a blind person in the country, who is appropriate, who can't get a dog at a token charge.

Even though the VA is authorized to purchase these animals, the guide-dog programs don't charge the VA, because they have been so successful in raising the money elsewhere.

We would like to follow that model; it is just that it takes time to build that sort of private sector support.

So, in the meantime, we need to be able to charge some third-party provider.

Senator ROCKEFELLER. Understood.

Dr. Willard, Senator Cranston has asked me to assure you that it is his intention that his bill, which is S. 2511, would provide for the VA to make partial payments for the monkeys in advance, so as to support their training and development prior to placement, and he is submitting a written question to the VA on this matter.

There may be more questions for you, but I want to say I appreciate your coming from Boston. It is not just that I appreciate what you said, but I appreciate that you had to come a ways to get here.

I am in the predicament that Jon described before, that I have to be at a Finance Committee meeting which I cannot avoid. I have to be there. It is on Welfare Reform. It is the final struggle on Welfare Reform, to see if we can do something to bring the bill to the floor so that it will pass.

Before I go, something very nice has happened that I think everybody ought to know about. I do this on behalf of Chairman Cranston and myself, and the entire committee and staff of the Veterans' Affairs Committee.

We want to congratulate Frank DeGeorge of the PVA, because his son, Frankie, was selected for admission to the U.S. Military Academy.

We think that you must be a very proud father, and we share your happiness. You have our heartfelt love and warmth.

Mr. **DeGeorge**. Thank you very much, sir, gentlemen, and all the members of the staff. I appreciate it.

Senator **Rockefeller**. Thank you.

I will again turn the gavel over to Mr. Steinberg, until I can return.

Dr. Willard, I guess that will be all for the moment, but you have stimulated with your ideas this Senator very much, and it is a very interesting approach that makes a lot of sense to me, whether it is expensive or not. So, thank you very, very much.

Dr. **Willard**. Thank you.

Senator **Rockefeller**. Senator Durenberger is here with Ms. Manthey, and I would like to welcome my colleague Dave Durenberger, who I welcomed yesterday at another hearing. He is here to introduce one of the witnesses in the next panel, Ms. Marie Manthey, who is a registered nurse from, of all places, Minnesota. [Laughter.]

Dave, I have explained that I have to go for the moment, so you will not take offense if I leave. I have to go to another meeting, so Jon will be chairing the meeting while I am gone.

If you would, now proceed to the introduction, I would be very grateful.

Senator **Durenberger**. Do you have to leave, or can I just tell you how great she is before you leave? [Laughter.]

Senator **Rockefeller**. Yes, you do that.

OPENING STATEMENT OF SENATOR DURENBERGER

Senator **Durenberger**. Well, now, I am going to be brief, because I do appreciate from my experience with you how thorough you are and how much time you commit to these issues.

But I have been at the health policy now for 10 years here in the Senate, and a long time before that, and you have been at it a long time in your various public capacities as well.

I think what both of us learn as we look at people who come up here in panels, and other things, is how much we rely not so much on association homogenized positions, sometimes, but on certain key people in various professions who seem to have an instinctive answer to the problems that they observe around them, just because they are problem solvers. And if there is a way to characterize the nursing profession, it is a problem solver.

But Marie Manthey, in our community, has always been the original problem solver. She did create what we now have come to call "primary nursing" back in the latter part of the sixties. She has held staff and teaching positions at the University of Minnesota; she has been at Miller and a couple of other hospitals in St. Paul; and she is a borderline genius, Mr. Chairman. [Laughter.]

That is intended as a compliment. She is the president of something called Creative Nursing Management. I don't know whether that is an oxymoron there or not, but probably is very appropriate.

But I guess you and I both know that this is an area in which we are desperately in need of creative ideas. So, even though you won't be able to stay for it, I wanted to come and recommend her testimony to you, and then to recommend her to your staff as a resource, as well, in the future.

Senator ROCKEFELLER. Great.

Senator, thank you very much; and, Ms. Manthey, we look forward to your testimony right now.

Ms. MANTHEY. OK.

Senator ROCKEFELLER. Senator Durenberger, thank you very much for being with us. We already are enjoying Ms. Manthey as a resource for our staff, and we appreciate your endorsement.

Senator DURENBERGER. Thank you.

Senator ROCKEFELLER. Thank you.

If the remainder of this panel could please come forward, they are Ms. Gertrude Keough, representing the American Nurses Association; Dr. Toni Sullivan, the chair of the University of Southern California School of Nursing and the American Association of Colleges of Nursing, a board member representing the board; and Ms. Claudette Morrissey, president of the Nurses Organization of the VA.

We are truly delighted to have such a distinguished panel of nurses with us, and again express the regrets of the committee that the circumstances that are unforseen that have confronted us this morning have taken away our chairman for the time being. We have appreciated the detailed written testimony of each of you.

I would like to say, on behalf of Senator Cranston, that the needs of the Veterans' Administration in the nursing area have been an extraordinarily high priority with him, as I am sure Ms. Ferguson would be glad to attest, who is with us today. For many, many years, as long as he has been the chairman or ranking minority of this committee and even before that.

We have been immeasurably assisted in our efforts to deal with the nursing shortage and also the nursing problems in the Agency, by having on the professional staff for the last year Ms. Sandra Isaacson, who all of you know, who is not only a registered nurse but also a master of hospital administration and also a former hospital administrator, a vice president of several hospitals, et cetera.

So we are learning, and we look forward to learning further from you this morning.

I believe that there are some additional witnesses with us accompanying you. So, as you testify, if you would introduce who is with you, please, we would appreciate that. And we would ask Dr. Sullivan if she would please lead off.

STATEMENT OF DR. TONI SULLIVAN, CHAIR, DEPARTMENT OF NURSING, UNIVERSITY OF SOUTHERN CALIFORNIA, AND MEMBER OF THE BOARD, AMERICAN ASSOCIATION OF COLLEGES OF NURSING, ON BEHALF OF THE ASSOCIATION

Dr. SULLIVAN. Thank you, and good morning.

I am delighted to be here, and I would like to introduce Polly Bednash. She was the legislative expert for the American Association of Colleges of Nursing.

I am pleased to be present today, on behalf of the American Association of Colleges of Nursing. Our organization represents 400 senior colleges and universities with schools of nursing, and we are very pleased that the committee has been concerned about the current nursing shortage and the changing nature of nursing education. And we wish to respond to S. 2462.

As you have noted, the current nursing shortage is extremely complex. The committee is to be congratulated for providing a multifaceted approach to solving the current nursing crisis.

Nursing is a vital part of any health-care system, and it is critical to the delivery of high quality care in acute care settings. Without well-educated skilled nurses, the delivery of health care in hospitals is impossible and will certainly suffer.

We applaud your efforts to enhance the environment in which nursing is practiced. The development of responsive pay and personnel management practices at the Veterans' Administration are vital to the recruitment and retention of qualified professional nurses.

But perhaps of even greater significance to recruitment and retention are your proposals to create new and innovative practice opportunities and to create programs which foster enhanced collaboration between physicians and nurses.

We believe that many of the issues surrounding retention of qualified nursing staff are quality of professional life issues that can only be solved through development of collegial relationships among all members of the health professions.

We would especially like to comment on the initiative to provide enhanced support of health professions' education programs in collaboration with the Veterans' Administration. This initiative, we believe, can provide invaluable support to both nursing and the VA health-care mission.

Nursing education is labor intensive. Indeed, the major costs associated with education of nurses are faculty related. Students receiving clinical training must have lengthy, intensive mentoring by clinical faculty.

Nurses receive extensive clinical training as a part of their baccalaureate education, and as part of their clinical training students of nursing often care for extremely ill patients, thus providing invaluable services to the clinical facilities in which they are training.

Our association is in fact completing a much needed study of the cost and benefits associated with having students in clinical training facilities. We are only in the preliminary stages of data analysis, but we can say that our findings indicate that numerous benefits accrue to clinical facilities that support nursing education.

Clinical faculty are often responsible for teaching and monitoring 10 students. Each student may be caring for as many as four patients. This translates to enormous responsibility for the clinical faculty, and also tremendous service to the health-care facility.

Nursing faculty, in fact, provide expert clinical knowledge and skills to nursing staffs when they are in the settings.

However, unlike medical education in which the cost of medical student clinical faculty are borne by the hospital, academic institutions assume the cost of supporting nursing clinical faculty.

Lower enrollments in nursing education programs, coupled with increased demands for innovative new programs and curricula, are straining the abilities of schools of nursing to stretch their constrained resources to support clinical faculty.

The development of joint efforts between schools of nursing and the VA would be extremely effective in assisting the schools to conduct quality clinical teaching programs and more effectively respond to changing educational demands.

Grants for the support of clinical faculty in VA facilities would provide a direct benefit to the Veterans' Administration in the form of clinical nursing expertise and skills provided by the nursing faculty.

An additional benefit of enhanced collaboration between schools of nursing and the VA is the recruitment of future nursing personnel. Students who train in a facility that is providing innovative support to their nursing personnel often choose to begin their nursing career in that facility.

So clearly, then, a side effect of the increased cooperation and collaboration would be a ready supply of nursing personnel for recruitment into VA facilities.

We would like to thank the committee and applaud the efforts of the committee in relation to S. 2462. We, as you, recognize that the future of our health-care system depends upon innovative and creative solutions to the current nursing crisis. We recognize the need to make both education and practice innovations to solve these complex problems, and we offer our support in these efforts and stand ready to assist in the implementation of these initiatives.

Thank you very much.

Mr. STEINBERG. Thank you, Dr. Sullivan, and let me also note that Senator Cranston regrets that he was unable to be here for your testimony this morning, but he certainly welcomes your input and appreciates your advice and counsel on many issues, not restricted, obviously, to the Veterans' Administration, and we thank you for coming all the way to be with us.

Ms. Keogh, would you please go next?

[The prepared statement of Dr. Sullivan appears on p. 246.]

STATEMENT OF GERTRUDE KEOUGH, ON BEHALF OF THE AMERICAN NURSES' ASSOCIATION

Ms. KEOUGH. Mr. Chairman, I am Gertrude Keough, and with me, on my left, is Donna Richardson, the assistant director of congressional and agency relations from the American Nurses' Association.

I am a former Director of the VA Health Professional Scholarship Program. I thank you on behalf of the American Nurses' Association and the Association of Operating Room Nurses for this opportunity to address veterans' health-care issues. ANA has represented VA nurses in collective bargaining since 1967.

This hearing reflects the committee's continued commitment to the provision of quality nursing care for the men and women of this Nation.

We would like to thank the committee for the passage of several provisions of S. 9 which enhance the ability of the VA to recruit and retain registered nurses. ANA and AORN endorse these additional shortrange strategies:

(1) Increase RN time with patients by reallocating resources and staffing, by employing nursing assistants and licensed practical nurses for support tasks, and changing the salary and benefit structure to help part-time nurses return to full-time work;

(2) Expand the overall pool of RN's by facilitating educational mobility, increasing financial aid to career changers and minority students, and increasing work-study programs.

A shortage of RN's often leads to inefficient use of a hospital facility. VA hospitals in the Atlanta/Augusta area have closed 125 patient beds. The Manhattan VA had to limit its cardiac surgery, and the Togus, ME VA had to close a ward because of the nursing shortage.

Regarding S. 2462, ANA and AORN support section 4, which would authorize the Administrator to appoint qualified VA employees to civil service positions without regard to the civil service register process, to expedite the recruitment and retention of health-care staff who are already oriented to the VA system.

The VA will therefore lose less of the VA-trained individuals to a more competitive private sector.

Section 5 of the bill decreases the amount of time within which the Office of Personnel Management can approve or disapprove special salary rates for title 5 employees.

We support the reduction of administrative delays which hinder the ability of the VA to ensure adequate qualified staffing for direct patient care.

S. 2462 creates a grievance resolution process for title 38 which parallels title 5. We do not believe that an employee's right to due process is any less when lesser disciplinary actions are involved. It is the degree of penalty, not the extent of due process, which properly fluctuates with the seriousness of the infraction. Consequently, we ask the committee to ensure that title 38 employees retain all due process rights, regardless of the infraction.

We wholeheartedly support section 8, which authorizes grants to assist implementation of cooperative arrangements between VA and the schools affiliated with VA to increase professional and technical health-care personnel.

We do have some concern about new health careers, as some people may see new health careers as a supplement for registered nurses.

I have run out of time, but we would like to thank the committee for the tuition reimbursement program and the extension of the VA health professional scholarship program.

Thank you.

Mr. STEINBERG. Thank you very much for your testimony, and we have received and reviewed your full statement. It will be fully considered. Ms. Morrissey, would you please go next?

[The prepared statement of Ms. Keough appears on p. 252.]

STATEMENT OF CLAUDETTE MORRISSEY, PRESIDENT, NURSES ORGANIZATION OF THE VETERANS' ADMINISTRATION

Ms. Morrissey. Mr. Chairman and members of the committee, I am Claudette Morrissey, a Registered Nurse employed full time as a staff nurse at the Veterans' Administration Medical Center in Brooklyn, NY.

I am here today as the President of NOVA, which is the Nurses Organization of the Veterans' Administration, and I thank the committee for the opportunity to appear before you.

NOVA is pleased to testify at this very important hearing addressing legislation that will affect the care of veterans in VA hospitals and clinics.

NOVA is concerned about the national shortage of nurses and what that will mean to our Nation's health care, and particularly to the veteran patient.

NOVA is also pleased to bring the perspective of working VA nurses to this hearing, and will provide comment on the appropriate sections of the proposed legislation.

As to section 4, NOVA does not oppose the waiver of the Civil Service hiring process, but we believe the key to attracting and hiring the VA-trained graduate will be the creation of a more favorable work environment.

Section 5: NOVA supports the proposed efforts to speed up the approval of the special salary rates and strongly supports giving employees on special salary rates the annual cost-of-living allowance.

There are over 100 VA facilities nationwide where registered nurses are denied this cost-of-living allowance because of their special salary rates. And each January this becomes a subject of great disenchantment.

Section 8: NOVA endorses the concept of the assistance to public and nonprofit institutions of higher learning. The schools of nursing needs the support to develop innovative programs that will reach out to corpsmen, paramedics, and others with health-care training and no clear career path to pursue a nursing education.

We, of course, hope this can be done in conjunction with employment at the VA, where the veteran patient's acuity mandates that nurses be at the bedside.

Since nursing's major occupation has always been and will continue to be providing nursing care at the bedside, NOVA supports this effort to increase the numbers of nurses with innovative programs.

NOVA also supports the efforts to inorease the supply of other scarce health professionals and established health occupations. However, NOVA cautions against the establishment of additional levels of health-care workers under the provision of development of new health-care careers.

NOVA agrees with our nursing colleagues outside the VA that new categories of health-care technicians are unnecessary, duplicative, costly, and can only serve to further fragment patient care.

NOVA wants to see an end to the use of nurses for nonregistered nurse work. Hospitals need to stop viewing nurses as the all-purpose employee who can stand in for anyone—a secretary, an escort, a janitor, whomever else is needed at that particular moment.

To attract and retain sufficient numbers of patient-support workers, the VA will have to look at a pay structure that makes it financially more rewarding to care for the VA grounds and buildings than to work in the occupations that support the care of patients.

NOVA is pleased to see a pilot project that will address the collaborative practice issue. We have testified in the past that this collaboration would improve professional and job satisfaction for nurses, and we welcome this confirmation that it is also good for the patient.

NOVA supports an expanded role for the chief nurse and creating new nursing models for furnishing care.

The rotation of shifts has long been one of the more onerous aspects of working as a nurse. Large enough economic incentives have not been tried to attract sufficient numbers of volunteers to work unpopular shifts, as is done in other 24-hour-a-day industries. VA nurses have indicated in past studies that this is a big issue for them.

NOVA thanks you for including this pilot study and hopes that the VA will act quickly to utilize the authority they now have in place.

In addition to the legislative proposals before us today, NOVA would like to encourage the support of the authority for the VA to hire retired military nurses, without these nurses losing their military retirement pay.

NOVA also supports the authorization of premium pay for licensed practical nurses and nursing assistants. We also urge the VA and this committee to listen to nurses in establishing realistic work loads.

We believe we have made a strong case for the need to use the limited resources available within the support and development of veterans' health-care programs. While some may think there is merit to a program of random drug testing for health-care workers, NOVA believes to divert funds at this time from the essential areas we have discussed would be a serious mistake.

Thank you, Mr. Chairman, for the opportunity to testify before this committee, and I will be happy to try to answer any questions.

[The prepared statement of Ms. Morrissey appears on p. 264.]

Mr. STEINBERG. Thank you very much, Ms. Morrissey. We are always delighted to hear from NOVA and to have NOVA with us.

Now if you have had an opportunity to recover from Senator Durenberger's magnificent introduction, Ms. Manthey, will you please proceed. [Laughter.]

We look forward with great anticipation to your testimony this morning.

Ms. MANTHEY. Thank you. I am not sure I have recovered from it.

STATEMENT OF MARIE MANTHEY, PRESIDENT, CREATIVE NURSING MANAGEMENT, INC., MINNEAPOLIS, MN

Ms. **Manthey**. It is my pleasure to be here, and I thank you for the invitation.

I speak in favor of all provisions of S. 2462. As a former nurse administrator who indeed had responsibility for departments of nursing, I found that to be a very strong advantage to operating efficiency and speak in favor of that recommendation.

I also speak in favor of the evening and night differential as a way to stabilize staffing, increase recruitment, and reduce turnover.

In my experience, collaboration between physicians and nurses is a wonderful concept and always beneficial to patient care, but it doesn't occur naturally, and I speak in favor of the idea of establishing a committee to facilitate and support physician/nurse collaboration.

The remainder of my comments refer to the part of the provision of this bill that deals with the development of new nursing models for furnishing care.

I would like to make a few comments on the nature of nursing, to begin with, and identify that nursing is a knowledge-based practice profession that deals with the diagnosis and treatment of people's responses to disease in such a way as to facilitate and further their health.

This concept of nursing as a knowledge-based practice profession has evolved from earlier ideas about nursing which viewed our activity as primarily a manual skill. In the days when nursing was considered a manual skill occupation, the education was predominately done through an apprenticeship system, and in those days student nurses staffed hospitals.

Since that time, the organization of nurses in hospitals has taken a great many interesting turns, and I have been fascinated in my work to study the organization of nurses at the unit level to understand what impact this has on the quality of care patients receive.

In the immediate post-World War II era, as we moved out of apprenticeship educational systems, with students being the staff of hospitals, auxiliary personnel that had been developed in World War II were available for health care at the unit level, and the organizational system that was developed is one called "team nursing" which was based on the theory of an industrial mass-production model of work organization.

The effect of team nursing and the industrialization of work that occurred through team nursing has left all of us with a great deal of sensitivity to the problems that can occur when auxiliary personnel are introduced to the work setting in inappropriate organizational models. And it is to the issue of organizational models that I am speaking today, not the introduction of auxiliary personnel, per se.

We found in our work with primary nursing that the development of a professional model for personnel at the unit level had a very positive effect on the care sick people received. In fact, it reintroduced us to an ancient truth about the care of the sick, and that is that people get better faster when they are cared for by some one person who really knows them, knows what is going on, and has the ability to manage that care from the patient's perspective.

That professional model of work organization has had a positive effect on the experience of sick people in hospitals today.

The shortage that we are facing—the current and the coming shortage—requires us to take a look at the utilization of that most scarce resource, the registered nurse.

We have developed a concept called "the partnership system," which allows for the introduction of auxiliary personnel to the unit level, under the direction of an individual nurse, in much the same format as the physician's assistant concept brought the utilization of that level of person under the direction of an individual physician.

In the system we are pioneering, the nurse-extender concept involves the development of a partnership between a senior, experienced RN—this is not a role for a new graduate; we are looking at utilizing senior, experienced RNs with 3, 4, or 5 years of clinical experience to be eligible for senior partnership—and a practice partner to be developed, who would work under the supervision of that senior partner, working the same shift, working the same schedule, caring for the same caseload of patients, and indeed signing a partnership agreement whereby a new bond is formed that has not hitherto existed in the organizational structure of nursing delivery systems in acute care hospitals.

This concept is being pioneered in a few institutions at this time, and it is my recommendation that the Veterans' Administration put forth the necessary funding to develop some pilot units of this concept.

The idea needs a great deal of study in order to be implemented in a carefully controlled way, and I believe the Veterans' Administration could be true pioneers in creating new roles for RNs that would alleviate the shortage and the salary problems that currently exist for senior experienced nurses.

That concludes the main thrust of my testimony. I would be happy to respond to any questions.

Thank you.

[The prepared statement of Ms. Manthey appears on p. 272.]

Mr. Steinberg. Thank you very much. We appreciate having the benefit of your experience and your vision.

Let me make one comment, before we proceed to a few questions, in response to Ms. Morrissey's concerns about the COLA and the special rates.

Although nothing in this world is certain, it does appear that OPM, which has been driving this issue, and which, as we understand it, has been in essence responsible for the VA's position on this matter, is going to make a change in policy to be effective next January, when it is anticipated at this point that there will be a 4 percent Federal employee cost-of-living increase.

So, we hope that that relief will be forthcoming, and that that will be good news for many of your members and all of the VA nurses that are at stations with special rates.

I see that Ms. Ferguson is shaking her head affirmatively, so I guess she anticipates good news as well.

I would like to ask each of you if you have any thoughts that you wish to share with us from an organizational standpoint, or a personal standpoint, on the way that the nursing service is structured in VA facilities and/or the way that the nursing service is organized within the Department of Medicine and Surgery in Central Office.

Do any of you have any thoughts that you would like to share with us on those issues?

Ms. KEOUGH. Mr. Chairman?

Mr. STEINBERG. Please. Ms. Keough?

Ms. KEOUGH. This is personal as well as for ANA. I will say, since I worked for the VA, and had a career with VA, I believe that there would be a chance to improve patient care if nursing were at a higher level where policies are actually made. I am talking about the ACMD level in the Department.

Mr. STEINBERG. You are speaking to Central Office at this point?

Ms. KEOUGH. Yes. This is not a new thought. It would also affect the chief nurse's role at the medical care centers if they could be involved in the higher circles before policies are actually made for them.

Mr. STEINBERG. It is our hope that, with the enactment of the recent law on May 20—I see Ms. Morrissey shaking her head affirmatively—with the requirement that the chief nurse be represented on all major policy committees within medical centers, that that in itself will be of assistance in the field. Of course, representation doesn't mean that anyone listens, but it is the first step to being heard, perhaps.

Ms. KEOUGH. Yes.

Mr. STEINBERG. Do any of the others of you have any thought about either the Central Office structure or the field structure?

Ms. MANTHEY. I don't feel that I have a great deal of understanding of the VA structure, but I do feel that nurse administrators throughout the country are at the highest level of administrative decisionmaking in their institutions and are members of all medical policy committees. And I don't perceive that to be the case in the Veterans' Administration.

Mr. STEINBERG. Well, we have just, by law, required that that be the case at each VA health-care facility, with respect to committees dealing with all phases of policy and budget at individual facilities.

Well, let me be more specific, then, and ask whether any of you would wish to give us the benefit of your thoughts on whether or not the chief nurse at a VA facility should report, as at present, to the chief of staff, or, as would seem to be more the model in the private sector, to the hospital director or perhaps the associate director.

Let me just ask you, starting with Ms. Morrissey, if you have any comments you wish to make on that point.

Ms. MORRISSEY. I believe the chief nurse should have the biggest say in what is happening in the nursing department, and to report to perhaps the hospital administrator himself instead of to his chief of staff, on the same level. This would seem more logical to me.

But again, I am talking from a staff nurse's level right now, and perhaps these other ladies have more insight into that. I don't know.

Mr. **Steinberg**. Dr. Sullivan, do you have any thoughts on that?

Dr. **Sullivan**. Yes, as a general concept, which I think should be inviolate. I think that medicine and nursing are peer professions, peer disciplines, and they should be collegial and report in a structure on an equal basis.

So, I am not going to say what particular way to organize is absolutely perfect, but I think that principle must be maintained. Whoever the chief of staff of medicine reports to, at whatever level in the organization, is exactly the same way it should occur for nursing. In both cases, these are the chief clinical experts in their disciplines.

Mr. **Steinberg**. When you are saying that there should be parity, should the parity be between the chief of nursing, or whatever the correct title would be, and the chief of staff for that particular facility? Or is the parity between the chief of nursing, for example, and the chief of the medical service, or the chief of the surgical service, or——

Dr. **Sullivan**. The parity should be between the head person for nursing and the head person for medicine. And I would expect that throughout the nursing service, throughout the medical service, there would be other departments and other chiefs of particular departments.

I would like to see a parallel structure throughout the organization.

Mr. **Steinberg**. So you are saying that the parallel is to what in the VA is called the "Chief of Staff"?

Dr. **Sullivan**. Yes.

Mr. **Steinberg**. Between the head person for nursing and the chief of staff?

Dr. **Sullivan**. Yes.

Mr. **Steinberg**. I see that Ms. Manthey is nodding her head affirmatively.

Ms. **Manthey**. Absolutely.

Mr. **Steinberg**. Ms. Manthey, let me follow up with a question on something that you touched on and that the ANA touched on in their written testimony, which says, "What the VA system needs is more nurses, not a new lesser-skilled practitioner." I believe Ms. Keough also touched on that in her oral testimony.

Taking into consideration your concept of nurse practice partners, what response would you have to that statement, or what comment would you have on that statement?

Ms. **Manthey**. I think that the VA probably does need more nurses. I will comment, again not from an expert testimony perspective about the VA's ratio of nurses to patients, but it has been my experience as a consultant that the VA has been understaffed, and that that is the conventional wisdom in most any community you go in. From the nursing standpoint, if you work in a VA hospital, you are going to work short-staffed. That seems to be the way the system operates. So I want to be clear and say that I believe the VA system probably needs more nurses.

We are facing a nursing shortage. And as we face that nursing shortage, there is a movement to introduce auxiliary personnel back into the system that had left through primary nursing.

My concept of the partnership does not speak to the need for more nurses but speaks to the issue, when there aren't enough nurses, of how should auxiliary personnel be brought into the system without compromising the integrity of professional nursing practice? And moving away from a professional model toward a more industrial model is the likely approach that is going to be taken if the partnership organization isn't taken seriously.

So, I am not speaking in opposition to more nurses, but to an organizational concept that will allow for the introduction of technicians or auxiliary personnel if needed.

Mr. STEINBERG. In an active partnership situation.

Ms. MANTHEY. That is right.

Mr. STEINBERG. Do any of the others of you have any comments, then? I guess it is fair to let the ANA respond to Ms. Manthey's concept as far as that is concerned.

Ms. KEOUGH. It seems to me that no matter what group is being trained or educated, nurses or auxiliary personnel of whatever, no matter what the group is, there is money involved in training.

It is hard to understand why we need to train new health-care workers. We know what nurses are. We know what they do. If we just had the nurses to do that, I think that is where our money should go.

Mr. STEINBERG. Dr. Sullivan?

Dr. SULLIVAN. Ms. Manthey's model does not address the nature of those technical workers. I think that is a critical question that has to be asked, and I think that Ms. Manthey is asking it and invites it to be asked by others.

Within the scope of nursing personnel at present there are workers, nursing manpower, who would very likely be the junior partners, or the practice partners—for example, licensed practical nurses, nurses prepared with associate degrees, and so forth. So there is the framework there for appropriately encompassing nursing workers at present.

It is also conceivable that another breed of nursing worker could be incorporated. But what is really critical there is that the content of the education, the scope of practice, and the responsibility for those workers be assumed within nursing, by nursing, by nurses.

So I think that this is a very interesting model. It is one of many that must be created and tested. It is very worthwhile to pursue, and it contains some of the critical elements that would be necessary in any nursing service delivery model as we look to meeting the needs of our Nation's citizens and the veterans in the future; because, no matter what, we are going to have a shortage of nurses.

Mr. STEINBERG. Ms. Morrissey, do you have any comment on this concept?

Ms. MORRISSEY. No. I think I agree wholeheartedly with what Dr. Sullivan has to say here, and with the ANA. I think that nurses have to be in charge of nursing, and whatever way that is decided is fine.

But it just seems inappropriate to bring in trained people from whatever or wherever to take over nursing's job. Nurses can be and should be in charge of nursing.

Mr. Steinberg. Ms. Morrissey, in your testimony this morning and in your written statement you urge that this committee and the VA listen to nurses in establishing realistic workloads. Does NOVA have a particular methodology that it endorses in establishing such workloads?

Ms. Morrissey. Well, we believe that the staffing methodology that the VA now has in place is very good. It is just that they are not following it.

The reason we say that is because, being at the bedside and a staff nurse, I constantly hear, "the VA nurse is overworked"—and we are. I can tell you from personal experience, I am a charge nurse on an evening shift in a stepdown unit for intensive care, and my patient ratio is 15:1. I have a 31 census, and there are two RN's on my shift.

In the SIC unit itself we have an eight bed unit, where the ratio should be 1:1 or possibly, on the outside, 2:1, and here have been shifts when the ratio has been 3:1 and sometimes 4:1. This is dangerous. You know, this is not good at all.

The system that is in effect could be used more efficiently. It is a good system as it stands, if they would just utilize it better.

Mr. Steinberg. Dr. Sullivan, could you describe briefly for us what your ideas are in terms of nursing education curriculum innovations that might be pursued as a result of the enactment of section 7 of S. 2462?

Dr. Sullivan. One whole set of innovations would have to do with accelerated options for so-called "atypical people" in seeking baccalaureate education in nursing. For example, programs that are especially designed for those who already hold a degree in another field, programs especially designed for those who already hold masters degrees in another field. We have one student who graduated from USC last year who had a PhD in physiology.

Baccalaureate programs or generic entry level masters programs for nurses who are already registered, for registered nurses who do not hold the baccalaureate degree.

So, flexible programs, accelerated programs, programs that recognize prior learning—this is one whole set of curriculum innovations that is really very important and has already been proven to be very successful. But we need to have these programs more widespread and even better developed.

Another whole area of real need which is harder to respond to in a quick, glib manner has to do with making nursing education curricula more attractive, enriching nursing education more.

The baccalaureate education in nursing is extraordinarily crowded. You are trying to jam a liberal education and a professional education into 4 years of academic study. Very often it takes 5 years or more, because a student is part time, or because the program is just so intensive; but in any event, trying to jam all of that in and trying to do it in a lock step manner, and trying to advance everybody along together is extraordinarily difficult.

It can become tedious. It can become, frankly, boring. And the student does not necessarily have the kind of college experience that they perceive they ought to have or they come to college expecting. And that is really a big problem.

It has been a big problem in terms of nursing being an attractive career choice. We focus so much of our attention on the practice setting and its lack of attractiveness; we probably do not focus sufficient attention on the educational programs themselves.

We really need to develop and test some creative new approaches that say that it just really isn't so important that every single person who comes into nursing has to have two semesters of chemistry containing x content, and so forth, that something else may substitute just as well, or perhaps there is a whole set of the natural sciences that one chooses from instead of these forced choices, and so forth.

So, we really, really need to really be creative and to break away from some of the really traditional lockstep kinds of approaches that we have had.

The American Association of Colleges of Nursing has a wonderful project, that is completed now, called "The Essentials of College and University Education for Nursing." It lays out four or five broadly defined very rich areas for nursing education—for example, the Liberal Arts, Ethics and Values Education, the Nurse in Practice, and so forth. It really provides a very exciting framework now to challenge all of us to relook at our nursing education programs and to try to enrich them, make them more attractive, so that we are educating people for life, we are educating problem solvers, we are educating people who can transfer knowledge from one setting to another, and so forth. I could go on forever. [Laughter.]

Mr. STEINBERG. That is very helpful. And I guess that another aspect of curriculum innovations is to build on the models that have been developed for second careers in nursing.

Dr. SULLIVAN. Right. Exactly.

Mr. STEINBERG. Finally, Dr. Sullivan, would you be able to submit to us a copy of the study on the costs and benefits associated with clinical training that you referred to on page 3 of your study?

Dr. SULLIVAN. Yes, we would be delighted to do so. When could we anticipate that?

Ms. BEDNASH. We expect the study to be completed in late summer. We are in data analysis at this point, and we have given you some preliminary findings in the testimony. When we are complete with the report, we would be very happy to share that with you.

There are two aspects to that study. Besides looking at the costs and benefits of having students in clinical agencies, we are looking at whole costs of an education for students of nursing. This is the first time that any data has been collected in terms of what it costs an individual to become a nurse.

We will have information related to the baccalaureate degree, the stepwise progression from an original degree that is not a baccalaureate on up to another degree, and the cost of a masters and a doctoral education.

Mr. STEINBERG. We will look forward to receiving that, and we thank you for your cooperation.

Again, thank you to each of you for traveling here. You have certainly spanned the country geographically, and I think you have spanned the subject matter intellectually. We are very pleased to have had you with us.

Thanks again.

Our next panel will speak to S. 2463, and if they would come forward, we would appreciate that very much.

Let me now welcome our next panel: Dr. Ming Tsuang and Dr. Richard Magraw, both representing the National Association of VA Chiefs of Psychiatry. Dr. Tsuang is Chief of the Psychiatry Service at the Brockton, MA, Medical Center for the VA; and Dr. Magraw is the Chief of Psychiatry Service at the Minneapolis VAMC. We welcome them.

Also on our next panel is Dr. Charles O'Brien, representing the American Psychiatric Association, and Dr. Patrick Boudewyns of the American Psychological Association, who is a Psychologist at the Augusta, GA, Veterans' Administration Medical Center.

We will start with Dr. Magraw. As I understand it, you and Dr. Tsuang are going to split your 5 minutes. So, if Dr. Magraw would lead off.

I am going to set this only once and let you figure out when the 2½ minutes comes. [Laughter.]

STATEMENT OF DR. RICHARD MAGRAW, CHIEF OF PSYCHIATRY, MINNEAPOLIS VA MEDICAL CENTER, ON BEHALF OF THE NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHIATRY

Dr. **Magraw**. Mr. Steinberg, we are glad to be here. I am the immediate past president of this association. We are speaking in support of S.2463.

It is our opinion that this bill will help VA services for the mentally ill come closer to parity with those services now provided veterans with other illnesses, such as heart disease, cancer, infectious diseases, and so forth.

I want to piggyback my comments on the introductory statement which Senator Cranston read when he introduced the bill on May 27. He noted that, despite the fact that approximately 40 percent of VA patients suffer from these mental illnesses and related problems, educational funds, training stipends, research resources, and staff positions for psychiatry have been disproportionately low.

We want to endorse the points made in that statement. We won't reiterate them here.

Since nearly 25 percent of all hospital beds in the country are occupied by persons suffering from schizophrenia, it might be self-evident, that something like 25 percent of research funds be dedicated for that study rather than the 2 or 3 percent as now.

Dr. Ming Tsuang, who is chairman of the Committee of Research for our association, will speak for us on the need of greatly expanded research in the field.

But before he does that, I want to make just a couple of points.

The first concerns the importance to veteran patients of developing a research capacity which is integrally related to patient care and professional services in the VA, as is envisioned in this MIRECC bill which has been proposed.

We certainly need more knowledge to treat mental illness, and research now will surely bring more knowledge in the future. But our patients need something more. They need a system where research is not divorced from patient care.

Our mentally ill patients will be better cared for today if that care is provided in an atmosphere of scientific investigation, with the associated enthusiasm for clinical work which the spirit of inquiry engenders.

A rising tide of scientific investigation spreads throughout the system and tends to lift all the boats, as it were. Such an environment also enhances recruitment of staff, and we have major problems with recruitment.

This is all part of the "academic connection," which is the package of research and education and clinical care which has well served veterans cared for in VA hospitals over the past 40 years.

To appreciate the importance of this "academic connection" to the mentally ill, we should bear in mind that, while Veterans' Administration hospitals and clinics provide 15 percent of all the medical and the surgical care which all U.S. veterans receive, the VA actually provides 50 percent of all the psychiatric care which veterans receive.

Second, it should be emphasized that we are in the time when brain sciences research is coming into its own. New knowledge is bursting out all around us like popcorn in the pan, and part of our efforts need to go toward fostering the application of new information to the direct care of patients.

Now I will turn this over to Dr. Ming Tsuang. His introduction is pretty well outlined. He is one of the most distinguished scientists in the entire VA, and the chiefs of psychiatry feel gratified to have him as one of our colleagues and speaking for us.

[The prepared statement of Dr. Magraw appears on p. 279.]

Mr. STEINBERG. Dr. Tsuang, please proceed.

STATEMENT OF DR. MING T. TSUANG, CHAIRMAN, RESEARCH COMMITTEE, NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHIATRY

Dr. TSUANG. Mr. Chairman, on behalf of the National Association of VA Chiefs of Psychiatry I would like to express my gratitude for the opportunity to testify in support of the proposed legislation S. 2463, and specifically in support of the proposal to fund five mental illness research, education, and clinical centers, which will be now abbreviated as MIRECCs.

Since I have already submitted a written statement, I would like to summarize my major points.

No. 1, psychiatry within the VA is at a critical juncture. Either it can move ahead and keep pace with the dramatic changes now occurring in psychiatric treatment or research, or fall steadily behind, perhaps irreversibly.

No. 2, this is first and foremost a matter of funding and manpower. For each psychiatry service to remain viable, the VA must recruit and retain skilled clinicians who are also active researchers and educators.

No. 3, traditionally, psychiatry in the VA has been underfunded in the critical areas of clinical services, training, and research, coupled with—and I would like to emphasize this—salaries which have largely fallen behind even State hospital remunerations. It is becoming increasingly difficult to recruit and retain these clinicians.

I will give you some examples in the critical areas Dr. Magraw has already emphasized.

Within the VA, psychiatry treats more service-connected patients than medicine and surgery, and actually has a larger "market share" of the veteran population as a whole.

In other words, a veteran with a psychiatric illness is more likely to seek VA assistance than one who has a medical illness. Yet, underfunding of psychiatric training is very obvious.

In contrast to the clear need of psychiatric services, less than 10 percent of the residency positions within the VA are allocated to psychiatry. Consequently, while patient-to-resident ratios average 6:1 in medicine, they average 16:1 in psychiatry.

Now, in terms of research, the same pattern of underfunding is evident in psychiatric research, where from 7 to 9 percent of the approved merit review research grant applications are funded for psychiatric and behavioral research and in dollar amounts cover less than 10 percent of the VA's direct research budget.

Between 1980 and 1984, only 7 of the 392 funded career development awards went to psychiatrists, and only 26 percent of the psychiatrist applicants were funded, compared to 42 percent of the total applicants within the VA who received funding.

Therefore, to attract a clinician who will enable psychiatry to provide clinical services, training, and stay in the forefront of research, there is an urgent need for a specially targeted project to develop a VA program with thoroughly integrated clinical academic quotas. And the MIRECC proposal is an important first step in that direction.

Now let me emphasize the importance of this proposal.

First, although the proposed MIRECCs do not address the magnitude of the programs confronting VA psychiatry, they will go part way toward finding solutions and can be expected to have a positive influence far beyond their proportionate cost, in view of their high visibility and their potential for attracting critical masses of scientists and clinicians to work intensively on the mental healthcare issue confronting the VA.

The second, MIRECCs, should provide a productive structure within which to delineate some of these pressing issues, propose clinically viable solutions, test those solutions on a small but reasonable scale, and demonstrate what is possible for clinician researchers to accomplish within the VA when there is administrative support and adequate resources.

So, finally, what are our recommendations?

One: It is critical for the success of this enterprise that the MIRECCs help promote the close cooperative ties that already exist between VA medical centers and major universities, and we are satisfied that the provision of S. 2463 will adequately address these needs.

Two: In our view it is also critical for the success of the proposed program that the MIRECCs be fully competitive with regard to scientific and clinical merit for the purpose of allocating resources.

As I have already pointed out, the problems of VA psychiatry exist on a national scale, and they can best be addressed by supporting special efforts like the MIRECCs that specifically allocate limited available resources to the groups most likely to make major contributions that will eventually benefit the entire VA mental health services.

Our position is that ongoing review of the MIRECCs in the form of regular 5-year site visits is the optimal way of achieving a balance between encouragement of scientific and clinical innovation, and the need for oversight and accountability.

In summary, the National Association of VA Chiefs of Psychiatry is fully supportive of the legislation proposed in S. 2463 to establish five centers for mental illness research, education, and clinical activities. We are convinced that it is only by promoting creativity and innovation in these closely interrelated areas that the VA will be able to perform its mission and truly meet the pressing mental health care needs of our Nation's veterans.

Thank you for your careful consideration of this opportunity.

Mr. STEINBERG. Thank you, Dr. Tsuang.

[The prepared statement of Dr. Tsuang appears on p. 281.]

Mr. STEINBERG. We will now hear from Dr. Charles O'Brien, who I neglected to note, and I apologize, is the chief of psychiatry at the Philadelphia, PA, Veterans' Administration Medical Center, and it is certainly inappropriate for me to slight my hometown. So, I apologize and ask if we could have your summary, please.

STATEMENT OF DR. CHARLES O'BRIEN, CHIEF OF PSYCHIATRY SERVICES, PHILADELPHIA VA MEDICAL CENTER, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. O'BRIEN. Thank you, Mr. Chairman.

I am also vice chairman of psychiatry at the University of Pennsylvania, and today I am representing the American Psychiatric Association, which is a professional organization of 34,000 psychiatrists nationwide.

Our organization strongly supports S. 2463, because we think it is a really good idea, for many of the reasons that you have already heard.

Because my written comments are available for insertion into the record, I will just make a few points in my oral statement.

First, this is a historical problem with mental health in the VA. It has gone on since the beginning of the VA, and it has been looked at by different independent groups, the most recent one being in 1985, when a blue ribbon panel reviewed the disproportionate lack of psychiatric research and academic programs in the VA.

For example, they pointed out that of 192 career scientist awards given out in the VA in a 2-year period, only two were in psychiatry.

They came up with the idea of centers of excellence, in order to stimulate and catalyze both research and education, improved quality of care, for psychiatry and mental health within the VA.

Now, it is important to make the point that neither this group, nor any of us, I believe, feel that there is a problem with the review process, as far as getting psychiatric research done in the VA. We think it is a rigorous review, and that psychiatry is treated fairly in the VA Merit Review Process. But the problem is that there aren't enough good applications.

And why aren't there enough good applications? Well, what you find is that psychiatrists in the VA are totally preoccupied with taking care of patients. They are tremendously overworked and generally understaffed.

You have heard some of the statistics. More than 40 percent of the bed days in the VA are in fact in the psychiatry services, and this doesn't even take into consideration all of the medical and surgical bed days that are actually created by psychiatric disorders, such as alcoholism. If you took that into consideration, you would have to say that the majority of the patients being treated in the VA are probably there because of a primary psychiatric disorder.

Yet, less than 10 percent of the research dollars in the VA are spent on behavioral science research, and less than 10 percent of the residency slots.

This is really critical, because if you look at my place, we have senior psychiatrists doing the work that residents do in other services such as surgery and medicine. They have to take care of patients all the time, and it is very difficult for them to get any research done.

Consequently, the most creative people go elsewhere, or they don't come to the VA in the first place.

At the present time we have 146 vacancies in the VA for psychiatrists, and some of these have been vacant for over a year. And this is only the tip of the iceberg, because many of the people that we have had to hire are people who really don't have many other options—they are not your most creative people. And, frankly, we could do better if we had a better climate for academic work in the VA.

Another point I would like to make is that we are missing a great opportunity, because as you have just heard, we are pretty much at the golden age of neuroscience research. There are tremendous discoveries going on right now in molecular biology and in neurophysiology, and these have been applied to brain function. We know more about how the brain works, and we know that a lot of disorders that in the past were thought to be due to psychological or social interactional processes are in fact brain disorders which need to be explored from their biological point of view, because there are probably better biological treatments that could be developed.

In the area of substance abuse, for example, addictive disorders, this is a national emergency right now, particularly with the connection between addiction and AIDS.

The VA happens to run the largest system of drug and alcohol treatment programs in the country, perhaps even in the world. By and large it is a very good treatment program, but there is very little research being done in these programs, and, Mr. Steinberg, this is a waste, and it is a waste that our country really can't afford right now in this crisis that we are in.

Mr. **Steinberg**. Let me interrupt you for a moment, because I think perhaps we have something helpful and useful to contribute on that issue.

I see Dr. Errera with a smile on his face, because he realizes that at a hearing a week or so ago he and Senator Cranston discussed that very subject, in the context of the extension of the VA contract program for community residential care and the evaluation which had been conducted.

At that hearing, Dr. Errera indicated that he thought it would be very advisable if the VA could have a similar evaluation of its own in-house programs, in order to find out not only in terms of the treatment of veterans but the treatment of all substance abusers, as you indicated, what works and what doesn't work in this very large $270 million substance abuse program which the VA runs.

As a result of that interchange and other information available to us, Senator Cranston has advocated, and up to this time we think successfully, that in an omnibus drug package which is being put together now as a result of a task force of the Democratic Policy Committee in the Senate, that there will be a special direction that evaluation money that is in there, given to I guess NIDA, would be made available for such an evaluation of the VA's inhouse drug and alcohol program.

Further, Senator Cranston has advocated that $45 million out of this new initiative, the total amount of which is somewhat unclear but might be in the range of $1 billion for treatment, be transferred to the VA.

You may remember that we got $10 million transferred in 1986 when we had the last omnibus substance abuse bill enacted in the fall of 1986, but we are trying to get a substantially larger portion of moneys allocated to the VA, because we have an ongoing program, which we think with the infusion of additional dollars could be effectively expanded to serve more veterans.

So I just wanted to assure all of you that I know you are all, in your capacities, concerned about substance abuse, and that is something we are actively working on.

Of course, proposing and getting finally enacted are two different things, and there is a long road; but I think we are off to a good start.

Dr. O'BRIEN. Well, let me make a comment, then, as someone who works in this area and as a member of the National Drug Abuse Advisory Council, that the President's AIDS Commission has put in a proposal for putting up to 30,000 new clinicians, treaters, into this field, and opening up many, many thousands of new treatment slots.

But you can't do this overnight. And this is part of what this legislation addresses. You have to build up an infrastructure. You have to train people. And that really takes years.

A lot of the drug abuse and alcohol abuse treatment which is going on today is not being administered by trained people who really know about the modern treatment techniques. Consequently, they are delivering an inferior standard of care.

Mr. STEINBERG. That is a very helpful comment.

Let me add something on the AIDS issue, because obviously that is of tremendous concern to this committee. Senator Cranston and Senator Murkowski have collaborated together in authoring legislation which has just been enacted in this omnibus bill enacted on May 20, setting forth some very comprehensive directions for the

VA with respect to training of staff, and confidentiality, and testing regarding AIDS.

But with respect to the relationship between drug abuse programs and AIDS, the Senate about 6 weeks ago, in passing the omnibus AIDS legislation, S. 1220, did authorize the appropriation of $75 million specifically for expansion of drug abuse programs for IV drug abusers, particularly in areas of high AIDS incidence.

Senator Cranston has made that a particular priority in this drug package that is being put together now.

At this point, it appears as though we will be successful, in targeting some additional drug abuse money into areas of high AIDS incidence.

So, the interrelationship of those issues, those problems, is certainly very much on our minds.

I interrupted you, and I apologize for that. I would like to give you 1 minute to conclude.

Dr. O'BRIEN. That is all right.

I will just conclude very quickly with a final point, and that is: How would these MIRECCs work? In fact, they would be centers of excellence where not only would advanced research be going on but also there would be a great deal of training, and also innovative clinical programs which would test new ways of delivering care as well as evaluating care and new types of treatments.

And we would be able to use the model of the geriatric research and education programs, the GRECCs, and profit from their experiences.

I think that this would have the effect of training more people in research and in modern clinical techniques within the VA. They would go out and have an increased probability of remaining in the VA, perhaps going to another VA medical center.

Even though there would only be five of these centers of excellence created by this legislation, I think it would have a catalytic effect in diffusing this kind of advanced work throughout the VA.

So, in conclusion, the American Psychiatric Association supports this legislation with enthusiasm. We don't think that it will solve all of the problems for mental health in the Veterans' Administration, but it will go a long way toward improving the balance and helping not only the care of veterans with mental problems but, because of the discoveries that will be applicable to all Americans with these problems, I think it will have an important effect on our country as a whole.

Thank you very much.

Mr. STEINBERG. Thank you, Dr. O'Brien.

[The prepared statement of Dr. O'Brien appears on p. 287.]

Mr. STEINBERG. Dr. Tsuang, as I understand it, you have to catch a plane shortly. Is that correct?

Dr. TSUANG. Yes.

Mr. STEINBERG. I wonder, Dr. Boudewyns, if I might ask if I could ask a question or two of Dr. Tsuang and then go to your direct testimony? Then we will have questions for the whole panel. Because Dr. Tsuang does have to depart very shortly.

Dr. BOUDEWYNS. Surely.

Mr. STEINBERG. Dr. Tsuang, in both your prepared testimony and in your oral testimony this morning, you talked about the low percentages of career development awards that are granted to psychiatrists and about other data which you believe demonstrates the importance of this kind of legislation.

Do you have any thesis as to why there is such a relatively low number of funded research proposals and traineeships for psychiatrists in the VA?

Dr. TSUANG. Actually, I was the chairman of the Research Scientist Development Review Committee of the National Institute of Health. And then when I was recruited by Harvard University as a professor of psychiatry there, and also as the Chief of Psychiatry at the Brockton/West Roxbury VA, I was asked to serve in the VA Career Development Committee.

From my own experience of serving the VA committee, I felt that committee's emphasis is mostly on bench-type of work, and the clinical service types of research, particularly with mental health, and behavioral sciences, were not well represented.

And even among the reviewers of the committee, I was the only one who represented mental health and behavioral sciences. The rest of them were nonpsychiatrists.

So in this case, the underrepresentation of psychiatry may affect the outcome of the reviews, and this would possibly translate into discouragement for the psychiatrists to apply.

Mr. STEINBERG. Some suggest that the quality of applications in the psychiatry field is lower. That is the traditional explanation that is provided for this.

Could you or any of the other panelists comment on that?

Dr. TSUANG. From my own experiences of reviewing the proposals for VA, in comparison with the proposals for the National Institutes of Health, the VA proposals of course are not as good as those of NIMH.

However, within the VA we have one Career Development Committee for all disciplines; whereas, in the National Institute of Mental Health there is a specific Research Scientist Development Review Committee for mental health and behavioral sciences within the National Institutes of Health. Therefore, the review process is quite different.

Although I agree with you, the quality seems to be not as good as the non-VA application, if we don't have an opportunity for the applicants from mental health and behavioral sciences to be considered separately and to attract new investigators to join VA research, there is no way to increase the number of funded research projects in mental health and behavioral sciences.

And now I have been in VA for almost 4 years. As I said in my testimony, I found it is very, very difficult to recruit the topnotch people to work for VA.

When I came to the VA, the salary level was about the same as the other teaching hospitals in the Harvard community. Now it is far, far behind. Also, when they come to VA psychiatry service, they have to do a lot of clinical work—not enough time for them to do research unless they get research grants to cover their time.

Mr. STEINBERG. If your association could provide us with any statistics based on the survey data that you have on that salary question, we would very much like to have it.

Dr. TSUANG. Oh, yes.

Mr. Steinberg. Let me ask you, how many members were on the career development review panel with you? What was the total number of members?

Dr. Tsuang. I cannot recall the exact number.

Perhaps you can answer that, Dr. Errera.

Dr. Errera. Twenty-one or 22.

Mr. Steinberg. Of whom there was only one behavioral scientist?

Dr. Tsuang. Yes. Only one psychiatrist, as I know.

Dr. Errera. And no psychologist.

Mr. Steinberg. That voice from the back was Dr. Errera.

Dr. Tsuang. Yes.

Mr. Steinberg. Dr. Winship, I wonder if you would be able to provide the committee with any thoughts—and if you would like to do this in writing, that would be fine—that the Chief Medical Director would have with respect to perhaps increasing somewhat the participation on such review panels, not only for career development but for research in general, of the behavioral sciences. Do you have any thoughts that you would like to share with us today? One out of 21 or 22 does seem rather meager.

Dr. Winship. I think that does seem low, and we will certainly be glad to do that.

Mr. Steinberg. Be glad to look into that, or be glad to increase it? [Laughter.]

Dr. Winship. To provide you with an answer. [Laughter.]

Mr. Steinberg. And we would appreciate a responsive answer to that question.

[Subsequently, the Veterans' Administration furnished the following information:]

[In 1986 Dr. Tsuang was appointed to a 4-year term on the Career Development Committee. He attended one meeting and then he resigned. Currently, Psychiatry is represented by Gary Tucker, M.D., Chairman, Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, Seattle, WA.]

The number of Career Development Committee members with expertise in a particular speciality is determined by the number of applications submitted by specialists from a specific field of clinical medicine. Among the standing members of the Career Deveopment Committee the specialities of psychiatry, neurology, infectious diseases, nephrology, hematology, surgery and pulmonary diseases are all represented by a single specialist. However, if during a review cycle more than 9 or 10 applications are submitted for review in a particular speciality, for that cycle of review one or more ad hoc reviewers are added to the committee. The committee is made up of 22 standing members who review applications for research training in medical, neurological, surgical and mental health and behavioral sciences. It is usually necessary to supplement the committee review by the addition of 4 or 5 ad hoc reviewers. Also, each application is evaluated by two ad hoc mail reviewers who are experts in the research proposed by the applicant.

There are no clinical psychologists on the Career Development Committee because, for several years now we have received no applications from psychologists.

Dr. Tsuang. May I interrupt again? Not just a career development award.

Mr. Steinberg. No, I was saying on the research grants as a whole.

Dr. Tsuang. Yes. As a whole, I can also emphasize one thing, sir. The majority of members in the Merit Review Board for Mental Health and Behavioral Sciences, are coming from non-VA institutions. They are mostly coming from university settings. In that setting, they are not fully aware of what is the critical issue involved in VA.

Mr. **Steinberg**. You are saying the reviewers are not themselves VA people, is that correct?

Dr. **Tsuang**. That is right. Of the VA employee, probably, if my estimate is correct, it is about 20 percent or 25 percent, and the remaining reviewers come from universities, or other research facilities.

Mr. **Steinberg**. You are saying these are university researchers who themselves have no direct affiliation with the VA?

Dr. **Tsuang**. Yes, that is my understanding.

Mr. **Steinberg**. And this is the review of all research?

Dr. **Tsuang**. Yes. Merit Review Board for Mental Health and Behavioral Sciences.

Mr. **Steinberg**. The VA merit review for research proposals?

Dr. **Tsuang**. Yes, I am talking about the VA Merit Review for Mental Health and Behavioral Sciences.

Mr. **Steinberg**. Which is one group evaluating both behavioral and nonbehavioral?

Dr. **Tsuang**. That is right.

Mr. Steinberg. We would appreciate a response on the implications of that statement as well, Dr. Winship, if you could provide that for us. That is, the extent to which those decisions are in the hands of individuals who do not have direct affiliation with the VA.

We also are obviously concerned about the representation on that panel of the behavioral sciences, but that is another point.

We would be glad to have you comment now, if you would.

Dr. **Winship**. I may just make a comment. And we will be happy to provide that.

[Subsequently, the Veterans' Administration furnished the following information:]

The primary mission of the Career Development Committee members, ad hoc committee members and ad hoc mail reviewers is to evaluate a proposal for its scientific merit. For trainees this includes a judgement of the quality of the research training experience. In order to achieve these objectives, we recruit to the committee peer scientists with the appropriate expertise to review the types of proposals that the committee will be asked to review. These scientists have also had extensive experience in the training of potential researchers. It matters not whether the members are VA or non-VA scientists; only that they have the appropriate expertise to review a particular set of applications. This constitutes fair and credible scientific peer review. It ensures the excellence of the research supported by the VA, and assures that the public funds entrusted to the agency are used appropriately.

Usually 30 to 40 percent of the members of the Career Development Committee (standing and ad hoc members) are VA scientists. At the most recent cycle of review (Spring 1988) 26 members participated in the committee review, and 11 of these are VA scientists.

Dr. **Winship**. I believe that a primary purpose for providing the kind of mix that you have heard is to attempt to develop the best kind of scientific expertise that we can, and not be limited to the VA in any sense for any of our programs. And I think that is the major purpose here.

So I think that it would be unfair to say that the decisions are specifically in the hands of non-VA people. I don't think that is the thrust of the whole issue; it is that we want the best scientific expertise to be brought to bear on our programs.

Mr. **Steinberg**. It is certainly admirable to hear the VA's commitment to getting the best views and advice, but it is interesting that that seems to be the case in the research program but not the case with respect to peer review.

We have had those discussions many times, about the fact that the VA is unwilling to subject its programs to outside review by what might be considered the best clinical reviewers who are non-VA, but nevertheless the VA adheres to the notion that it can do the job internally.

So, I see some contradiction there. Obviously, our bias would be in the direction of having more non-VA in the review of quality of care.

But I think the point that was being made by Dr. Tsuang and Dr. Boudewyns' comment—and I will get to you in a moment—is that it is the vast majority. It is not that we have integrated the review process in such a way that non-VA and VA are integrated, which certainly seems appropriate, and I don't believe any of the panelists are suggesting that should not be the case, but rather that it is something like 75 percent to 25 percent, as I understood the data, which does seem rather disproportionate.

If you would look at that. I understand your point as well, and obviously we think a broad range of viewpoints is very desirable. But if you would look at that and comment on that, we would appreciate it very much.

Dr. **Winship**. We will be glad to do that.

[Subsequently, the Veterans' Administration furnished the following information:]

Applications of psychiatrists fare as well in the Career Development review process as applications from other specialities. In the eight most recent cycles of review (fiscal years 1985 through 1988), a total of 976 applications were reviewed and 34 percent were approved for funding. During this same period of time 43 applications of psychiatrists were reviewed and 33 percent were approved for funding.

Mr. **Steinberg**. Dr. Winship, feel free to remain, in the event that something else comes up that you wish to comment on.

Dr. O'Brien.

Dr. **O'Brien**. I would just like to draw a distinction between the review process for career development awards, where there is only 1 psychiatrist out of 21 and where they review grants or applications from all fields, and I would subscribe to the notion that psychiatry is underrepresented there; but I would distinguish that from the merit review boards which review specific categories like areas of, say, immunology, neuroscience, mental health, pharmacology, and so forth.

There, having served on those and also having reviewed them as a member of the VA's Research Advisory Council, I am impressed that the rejection rate varies from round to round but for mental health, psychiatry, psychology, and so forth, it is roughly within the range of most of the others. I think that the review is generally a good process, and having outside-of-VA people on it is an excellent idea.

So my explanation for the lack of VA research in this area is that our VA psychiatrists are just too overburdened with direct patient care, for more than 40 hours a week—they can't get it done in 40 hours a week—that they don't have time to do research or to write good applications. And those who could do that are being scared away because of all of the reasons Dr. Tsuang mentioned.

Mr. **Steinberg**. Dr. Magraw.

Dr. **Magraw**. I would like to comment, but I would rather wait until Dr. Tsuang catches his plane.

Mr. **Steinberg**. Yes. All right, we will do that.

I have one last question for him, then I would advise that you go. But you are not very far away from National Airport. You are going to National Airport?

Dr. **Tsuang**. Yes.

Mr. **Steinberg**. OK. Thank you. If not, you weren't going to make the plane, anyway. [Laughter.]

Do you believe there are special research opportunities in the VA that possibly don't exist through the NIMH? That is, do you think the VA has some unique opportunities to take a leadership role in any particular areas of mental illness research?

Dr. **Tsuang**. Yes.

I was a vice chairman of psychiatry at the Brown University, and when I was asked to come to look at the Brockton/West Roxbury VA, which is affiliated with Harvard—I didn't come to work because of Harvard—I was really impressed with the patient population, with 360 beds there, with diagnoses of schizophrenia and drug abuse and alcoholism. It is a great opportunity for us to develop the research within the VA.

So, when I came to Brockton/West Roxbury VA, there were no funded research projects initiated from psychiatry services—we now obtain about 15 grants—the reason is that we are capitalizing on VA resources, particularly the patient populations. We can compete, not just within the VA but compete outside of VA; for instance, from NIMH.

Mr. **Steinberg**. These 15 grants include all sources, VA and non-VA?

Dr. **Tsuang**. Exactly. And the VA grants are actually the minority.

Again, I would like to reiterate the composition of the Merit Review Board for Mental Health and Behavioral Sciences, which is chaired by a non-VA psychiatrist, and 75 percent of the members are non-VA employees, they review the proposal primarily based on scientific merit alone, which I understand fully well, since I always pursue for the excellence in research.

However, after I came to VA, I realize that the VA has a unique issue in mental health research. Unless one works there, one doesn't know what is important, aside from scientific merit, from more realistic points of view.

So, when the priority score of each research proposal was given, of course, one should consider scientific merit of the proposal, but other considerations are also very important. Since I am new to VA coming from outside, is one of the reasons that, I guess, Dr. Magraw asked me to come to testify. My suggestion is that at least there should be 50-percent representation from VA physicians or VA scientists in the Mental Health and Behavioral Sciences Review Board. And it should be chaired by the VA employee, if there is no conflict of interest.

So, may I be excused?

Mr. **Steinberg**. You are excused.

Dr. **Tsuang**. Thank you very much.

Mr. **Steinberg**. We appreciate your journeying down here, and we wish you well in making your plane.

Dr. **Tsuang**. And thank you very much.

Mr. **Steinberg**. Please leave. [Laughter.]

Dr. Magraw, you wished to comment on this issue?

Dr. **Magraw**. Well, I wanted to comment on how it is that we lag so far behind. That is what you are asking.

I agree both with what Dr. Tsuang and Dr. O'Brien have said but one issue is that our field has lagged very far behind.

My perspective may be unique as I was originally a surgeon in general practice, then I was a professor of internal medicine and also psychiatry and neurology, so I am not just seeing this as a psychiatrist.

The fact of the matter is that what we know about the brain has lagged behind other parts of medicine. The brain has been inaccessible. It is locked inside of a bony skull; it is chemically isolated from the rest of the body; it is the organ of the mind and hence is too precious for casual study; and it is light years beyond anything else in medicine in terms of its complexity.

If you were one of my fellow internists, I would be sort of lecturing you and say, "Doctor, I want you to understand, I don't want any of this patronizing business about psychiatry not knowing much. Of course, we don't know much yet, and that is the principal reason why our research efforts have been at a kind of kindergarten level. We need a pump-priming period to get caught up with the rest of medicine that has had an opportunity to study things, like the heart and the kidney, in a way that we have not been able to study diseases of the brain." Only now, as Dr. O'Brien said, are we on the threshold of a golden age in brain science.

Mr. **Steinberg**. Dr. Boudewyns, we are going to turn to you now for your statement, but let me also note that it was perfectly open to you if you wished to make any comments on any of the questions or discussions that we have had up to this point, prior to your starting your statement.

Dr. **Boudewyns**. Well, only that Dr. O'Brien has already covered some of the points that I have made in my testimony, and you have my testimony. So I will try to pick up from there and be brief.

STATEMENT OF DR. PATRICK BOUDEWYNS, CHIEF OF PSYCHOLOGY SERVICE, AUGUSTA VA MEDICAL CENTER, ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Dr. **Boudewyns**. Mr. Chairman, I am Pat Boudewyns. I am Chief of the Psychology Service at the VA Medical Center in Augusta, GA, and I am also a principal investigator of the Research Service at that VA.

Mr. **Steinberg**. Let me apologize for mispronouncing your name. We had lots of discussions about how to pronounce it, and we obviously didn't figure it out correctly. So, I apologize.

Dr. **Boudewyns**. Most people don't come up with the long "O." You did very well, though.

This year I am president-elect of the division of psychologists in public service of the American Psychological Association, and I am testifying today on behalf of the 90,000 members of the American Psychological Association.

APA is the major scientific and professional society representing psychology in the United States. Many of our members are researchers and practitioners in the VA.

According to 1987 data, there were 1,587 psychologists who are trained as scientists-practitioners, employed full time in the VA, and I believe about 170 part-time psychology scientist-practitioners.

Thank you for inviting me to testify regarding S. 2463, a bill that authorizes the establishment of five mental illness research, education, and clinical centers within the VA. These centers would be an important addition to current VA research programs that are already recognized for their excellence.

I was encouraged to note in Senator Cranston's statement upon introduction of this legislation that the stated mission of these centers would be to "coordinate research, the training of health-care personnel, and the development of improved models of clinical service for eligible veterans."

VA psychologists have long been active and are leaders in research design and methodology in the VA and throughout our health systems, and in academic and research centers throughout the world.

The coupling of research and clinical services is certainly a winning combination, and these could be truly "centers of excellence."

Now, similar to the very productive geriatric research, education, and clinical centers, or GRECCs, as they are called, established by the VA in the early seventies, S. 2463 proposes multidisciplinary centers, and this is what I would like to speak to.

Multidisciplinary centers would allow the several mental health disciplines, including psychologists, psychiatrists, and other physicians, social workers, nurses, and other mental health specialists to interface in their research, training, and patient care efforts.

This multidisciplinary approach is of particular importance to the various mental health professions that must assess and treat an array of interactive emotional, physical, cognitive, and interpersonal problems that mentally ill patients present us with.

The present VA system of research funding is primarily concerned with providing resources to a single researcher, addressing his or her circumscribed area of interest, on a short-term basis.

While most areas of physical medicine can be effectively investigated in this manner, many areas in mental health and illness, such as psychological treatment of outcome research, for example, which is my area, require intensive multidisciplinary efforts with long-term followup that can be more effectively addressed by cooperative studies designed in centers such as those proposed by the legislation.

Not to skirt the issue of budgetary considerations, research funding is cost-effective in the VA. I believe the figure I heard is that less than 2 percent—I rode over here with Dr. Green, and he said he thought it was down to 1.6—of all funding for DM&S goes to medical research, a very small amount for what it has produced over the years.

A relatively small investment, then, currently a fraction of the total VA health costs, can serve to facilitate the development and utilization of behavioral techniques that will in the long run save money in nonmental health-care utilization, while generally improving the quality of health care delivered in the VA.

I commend Senator Cranston and the original cosponsors of the bill—Senators Murkowski, Matsunaga, DeConcini, Rockefeller, and Graham—and the Veterans' Affairs Committee for their concern with the mental health needs of veterans.

Illness, whether it be mental or physical, benefits immeasurably from research, education, and the application of patient care.

Depression, AIDS, post-traumatic stress syndrome, alcoholism, substance abuse, and a host of other disorders are serious national problems that disproportionately affect veterans. We must not hinder their work by devoting too few resources to this cause.

On behalf of the APA, I thank the committee for the outstanding work that you are doing with regard to health needs, particularly the mental health needs of veterans. Thank you for the opportunity to testify on this outstanding piece of legislation, and I look forward to seeing mental illness research, education, and clinical centers come to fruition in the near future.

Mr. STEINBERG. Thank you very much, Dr. Boudewyns.

[The prepared statement of Dr. Boudewyns appears on p. 297.

Mr. STEINBERG. As you indicated in listing the cosponsors—and we are delighted to have our ranking minority member, Senator Murkowski, join with Senator Cranston in this legislation as well as the other four members—the number adds up to six. There are only 11 members of this committee. So it should be quite clear that this committee will move that legislation forward, and I think there can be little doubt that it will be passed by the Senate.

I might just suggest that there are two bodies, two coequal bodies, here in the Congress, and your organizations could obviously be helpful in educating the other body with respect to the merits of this legislation in the course of this summer. We would welcome your efforts in that regard, and I am sure that the other body would welcome them as well.

I might indicate also, in terms of your testimony and the contributions of the American Psychological Association, that one of the individuals—in addition, obviously, to the Kety Committee report—who played a major role in inspiring this particular legislation is himself a psychologist, a VA psychologist. So, we are indebted doubly to you, not only for your testimony today but for the help that your discipline has given us in developing the legislation.

Now if I could turn to a few questions.

Dr. O'Brien, you stated that 21 VA facilities report vacancies in psychiatry that have lasted longer than 1 year, and that the total number of vacancies is 146. Are there insufficient numbers of psychiatrists available in general to fill those slots, or is the VA simply not able to compete effectively for them?

Dr. O'BRIEN. I think the VA has a serious problem in competing. As you have already heard, the salaries are higher elsewhere, and the working conditions are generally much better. The other point is, even if all 146 of these were filled, there still would not be enough psychiatrists for the work load that we have. So, I think there are many reasons for those persistent vacancies.

As I said before, it is the tip of the iceberg, because we have had to accept some people at some VA centers that we might not have accepted if we had been more competitive.

Mr. **STEINBERG**. Do you have any suggestions—and I would extend this to Dr. Magraw and Dr. Boudewyns as well—as to any steps, short-term or longterm, that could be taken to help attract high quality psychiatrists to the VA?

Dr. **O'BRIEN**. Do you want to address that?

Dr. **MAGRAW**. The association that Dr. Tsuang was speaking for came up with a series of recommendations during the past year, and I believe they have been part of Dr. Tsuang's written testimony. If they aren't, we will include that.

Mr. **STEINBERG**. No, I think he is supposed to submit them. So would you please make sure that they get to us?

Dr. **MAGRAW**. Yes.

[Subsequently, Dr. Magraw furnished the following information:]

RECRUITMENT AND RETENTION OF PSYCHIATRISTS IN VA MEDICAL CENTERS

Meeting in VACO September 21, 1987

A recent survey of Psychiatry Services in the VA system indicates that in fiscal year 1988 approximately 550 to 600 additional, fully trained and qualified psychiatrists would need to be recruited to completely fill out the approximately 1,550 FTEE positions for staff psychiatrists in the entire VA. (Approximately 400 of these are now vacancies or will become vacancies in 1988. The balance includes staff psychiatrist positions now filled by persons who have not had psychiatric training.)

In addition there are indications that because of the rates of remuneration now available to qualified psychiatrists in public mental hospitals, there will be further erosion in the retention rate of psychiatrists in the VA. (In a substantial number of State mental hospital systems, psychiatrists earn $20,000 to $40,000 more per year than comparable pay in the Va system.)

Hence on the basis of existing and forseeable needs for psychiatric staff in the Veterans' Administration system, and in the light of national demand for psychiatrists, we make the following recommendations:

Recommendation 1.—The Department of Medicine and Surgery declare Psychiatry to be a "scarce specialty" with corresponding potential increases in incentive pay (analagous to what anesthesiologists, pathologists, etc., are now receiving). We further recommend that, as is appropriate to the recruitment and retention situation in individual medical centers, the respective Medical Center Directors increase the incentive pay for psychiatrists on their staff pursuant to existing DM&S authority.

Recommendation 2.—Where appropriate, additional incentive pay should be encouraged and authorized on the basis of geography. This would include those nonaffiliated, nonmetropolitan VA medical centers having extraordinary difficulties with retention and with recruitment of psychiatrists. Such authorization should be for sufficiently lengthy periods to effectively enhance recruitment and encourage retention of psychiatric staff.

Recommendation 3.—Efforts should be made to expand psychiatric residency programs in the VA in such a way that the pool of potential new psychiatrists available to the VA medical centers is increased.

Recommendation 4.—Wherever feasible, clinical workloads for psychiatrists should be maintained at levels consistent with the academic achievement of the staff psychiatrists. Research facilities, funding and time should be increased in order to provide opportunity for the academic development of psychiatrists and for the maintenance of an appropriate academic milieu for resident education.

Committee on Recruitment and Retention of Psychiatrists—NAVACOP
Chairman: John Benson, M.D.—chief, Psychiatry, VAMC Augusta GA

Note.—These recommendations were developed by a committee of VA Chiefs of Psychiatry, subsequently endorsed by the National Association of VA Chiefs of Psychiatry (NAVACOP). In October, 1987, they were submitted to the ACMD to the Chief Medial Director of the Veterans' Administration for his consideration.

Mr. STEINBERG. Dr. O'Brien, did you want to make a comment?

Dr. O'BRIEN. I could just add that this is a very long and complex question, and I would rather have all the data right at my fingertips.

But I can tell you that one issue has to do with the questions about the way that medical care is reimbursed through the so-called "RAM Model," which I am sure you are very familiar with. And in many cases, psychiatry services, because of their high volumes, have in fact been winners in the RAM, but it has not really resulted in additional funding.

So, consequently, in some cases there have even been cuts or they are just staying still, despite the high volume. I think it really requires an overall look at the way mental health is regarded within the VA.

For perhaps many reasons—and you have to look at the fundamental process here—of the whole population of eligible veterans out there, those with mental disorders are more likely to seek services at the VA. So consequently, the veterans with mental problems are disproportionately represented; and yet, the services for them, based on data that we have already stated here today, are below their proportion in the veteran medical patient population.

Dr. BOUDEWYNS. I would just like to add that opportunities for research for psychiatrists would be one way to attract psychiatrists.

Mr. STEINBERG. Right.

Dr. BOUDEWYNS. That is one thing that we do emphasize at Augusta now, and we have been more successful in attracting quality psychiatrists since we have had these programs.

Dr. MAGRAW. However, if I could add to that also, in fact even today we are losing people. I just lost three people to the University of Michigan specifically for this reason, three young psychiatrists which are almost impossible to replace.

The figure that Dr. O'Brien used of 146, I know where it comes from; it is kind of the official figure. But it is probably very conservative. Maybe there are twice that many of vacancies. I carried out a survey about 10 months ago, and that was closer to the figure I had—more like 300 than 150.

Mr. STEINBERG. Dr. Winship, is there any current effort or study or task force looking into the question of recruitment and retention in the mental health field in DM&S?

Dr. WINSHIP. Dr. Magraw and some of his colleagues have been addressing my office, have in fact just recently had a meeting with Dr. Graham, my associate, to bring to our attention this problem. Dr. Magraw, I believe, will be getting back with us.

In the meantime, we are pursuing from our end, evaluating the proposals that they have made, or the data, and the issue.

I would say that I am very interested in hearing the details of this problem and attempting to work with them to see what sort of measures we can take to improve this situation, because I think they are exactly right.

Mr. STEINBERG. We would very much appreciate it if you would communicate to the Chief Medical Director the obvious interest of this committee in the mental health field and mental health research, as evidenced by the recent enactment in the omnibus bill of a specific mention of mental health research as one of the missions of DM&S.

We would suggest preliminarily, and would like your response, that a task force be established under Dr. Errera's leadership to report to the Chief Medical Director about this problem, so that we might not allow it to become anymore exacerbated than it seems it already is and we could be looking for solutions.

Obviously, one solution is the exercise of the existing special pay authorities, which the VA does have and which I am not sure are being exercised to the maximum extent they might be in the area of psychiatry.

Dr. WINSHIP. Well, I think in the area of psychiatry, primarily, since the psychiatrists are title 38. The special pay authority that we have in other areas, of course, don't extend to that. We do have a physician bonus authority, and I guess that is what you were referring to.

Mr. STEINBERG. Right, that is what I am talking about.

Dr. WINSHIP. I believe that the steps that Dr. Magraw and the VA Association of Psychiatrists has launched would be a good starting place for us to take that up. I certainly will talk to Dr. Gronvall about that.

Mr. STEINBERG. And if you would, report back to us.

[Subsequently, the Veterans' Administration furnished the information which appears on p. 197.]

Mr. STEINBERG. Dr. Magraw, if you would stay in touch with us on this issue, in terms of providing an appropriate mechanism for these ideas to be considered and acted upon in the Department, we would very much appreciate it.

Dr. MAGRAW. All right.

Mr. STEINBERG. Dr. O'Brien, you spoke about the great clinical demands on VA psychiatrists' time and how that adversely affected their time for research. Do these clinical demands differ significantly from the clinical demands on psychiatrists in other teaching hospitals, non-VA?

Dr. O'BRIEN. Yes, as a matter of fact, they do, because I happen to work in both places; I am only a part-time VA physician. I can tell you that there really is quite a difference.

And also the amount of assistance that the physicians get in the university hospital, in terms of the number of ancillary personnel, is much more luxurious. In fact, at the VA we have a great shortage of social workers, a great shortage of nurses and pharmacists, and right down the line. So, consequently, psychiatrists find themselves acting like social workers, or wheeling patients around and doing things, and trying to arrange placement, and so forth. It is not a very efficient use of their time.

But sometimes for expediency's sake you do it, and you do it at night and on weekends, whatever is necessary. There are very dedicated people working in psychiatry in the VA; but in fact, as you hear, there is a shortage, and the working conditions are such that some of the more dedicated ones are being lured away for other jobs that both pay better and have more time for scholarly pursuits.

Mr. STEINBERG. And in these other areas, in the other non-VA facilities, there are greater opportunities—certainly in university affiliated facilities—greater opportunities for research and more time, particularly, than there are in the VA?

Dr. O'BRIEN. That is correct.

Mr. STEINBERG. Dr. Boudewyns, do you have any comment on that issue vis-a-vis psychologists, and any comparisons to psychologists working in other health-care settings?

Dr. BOUDEWYNS. The psychologists in the VA for the past 8 to 10 years haven't had quite the problem in recruiting, of course, as psychiatry and social work have.

Recently, however, we have noted that we are starting to have a problem again, because the pay has not kept up with the private sector. So, for the first time in years we are going to have a booth at the American Psychological Association Convention this year to recruit.

So, although we haven't had a problem in the recent past, I can see where this could become a problem if we can't increase our pay up to what psychologists are now getting in the private sector.

Mr. STEINBERG. The Kety report—and Dr. Magraw gave these figures this morning—cites the figure that, while the VA provides 15 percent of all the medical and surgical care which veterans receive, it provides 50 percent of all the psychiatric care that veterans receive. I assume that is inpatient psychiatric care.

Do any of you have any thesis to account for that disproportion?

Dr. MAGRAW. Well, certainly an important part of it has to do with the vulnerability of people with these illnesses to limitations of earnings. They tend to be living a rather marginal existence in many instances and simply cannot avail themselves of other sources.

And of course, the point that Dr. O'Brien made, that a proportion of service-connected veterans in psychiatry tends to be considerably higher than other services, is also an element in this.

Mr. STEINBERG. Do you have any data to support that, on the service-connected proportion?

Dr. MAGRAW. Well, I was just thinking as I made that assertion, I can tell you about our circumstance. For instance, over long-term experience in our mental health clinic, has been that about 85 percent of the people attending were service connected.

Mr. STEINBERG. Are we talking about service-connected for their mental health problem?

Dr. MAGRAW. Yes.

Mr. STEINBERG. And is that the outpatient clinic we are talking about?

Dr. MAGRAW. Yes. I can't give you inpatient figures. I could try to get them.

Mr. STEINBERG. Would you supply those for the record for us?

Dr. MAGRAW. All right. They would not be anything like that.

Mr. STEINBERG. Right.

[Subsequently, Dr. Magraw furnished the following information:]

VETERANS' ADMINISTRATION MEDICAL CENTER

Minneapolis, Minnesota

PSYCHIATRY SERVICE (116A)

(Percentage of Active Cases—Service Connected)

	1985	1987
Mental Health Clinic	85	64

1988—Percentage of Inpatient Psychiatry Admissions which were Service Connected (Ending March 31, 1988)—48

Dr. MAGRAW. But to contrast that, my impression is that for the rest of the medical center the proportion of service-connected veterans in the clinics would be not any greater than 40 percent.

Mr. STEINBERG. Well, I think systemwide it is running 50 to 55 percent now. Dr. Winship, is that approximately right for outpatient service connected care?

Dr. WINSHIP. Outpatient service-connected care? Yes.

Mr. STEINBERG. And, of course, that is not service-connected care, either.

Dr. WINSHIP. No, it is just all service-connected.

Mr. STEINBERG. So no one knows exactly, within that 50 to 55 percent, what the service-connected, for a service-connected condition, care is. But it is probably no greater than 50 percent of that percentage, I would think, at the most.

So, your actual service-connected direct treatment load is very, very high.

Dr. MAGRAW. Yes.

Now, I have to say that those figures are at least 2 years old, and if I am going to give you something I had better note these are approximate and then give you something accurate.

Mr. STEINBERG. Please do that.

Dr. MAGRAW. I will.

Mr. STEINBERG. Dr. O'Brien, do you have anything to add on that?

Dr. O'BRIEN. Just in support of what Dr. Magraw says. In our mental hygiene clinic, which has about 2,500 and sometimes up as high as 3,000 veterans coming, our service-connected rate runs between 90 and 95 percent.

Mr. STEINBERG. Again, we are talking about being treated for service-connected mental illness?

Dr. O'BRIEN. Yes, that is correct. So, that supports the kinds of numbers that he has. I don't know what it is systemwide for psychiatry; but I do think that, based on my experiences in treating these patients, this should be motivation for the VA to want to do research on chronic mental illnesses, because we have people who are World War II veterans who have been coming to our clinic since the 1940s and 1950s.

Now, we can show that they are still ill, and that if we stop treatment—in fact, some of them, when they have dropped out, they have wound up in the hospital. So, treating them as outpatients is preventing hospitalization.

But our treatment is in fact maintaining them in a state of partial remission. But generally they are not well enough so that they are able to go out and be gainfully employed.

Also, of course, there is the issue of the pensions, which figures into this as well. There are certain negative incentives about employment there, which is another issue which always bothers those of us working in the VA, because our hands are tied in terms of setting incentives.

But the point is, there are a lot of research questions here which could be addressed if we were able to do more research on these patients. They are a vast population which is sitting there using medical services. When we ask them to take part in research, they volunteer quite readily. So we are not tapping this wonderful resource, and we could be saving money, perhaps, if we learned a way to treat them better.

Mr. STEINBERG. Do you have any idea what your inpatient service-connected proportion might be?

Dr. O'BRIEN. Yes. In our case it is very high, because we don't have enough beds, and we give preference, of course, to those who are service connected. Most of our patients are acute emergencies, anyway.

So, our service-connection rate for inpatient, for general psychiatry, is something well over 50 percent. It is high, I think, for the system.

Now, if you looked at our substance abuse programs, many of these people are not technically service-connected, although in fact that is a special situation, as you know.

Mr. STEINBERG. And as the Supreme Court seems to know.

Dr. O'BRIEN. Right.

Mr. STEINBERG. Are you getting new psychiatry beds in your new building?

Dr. O'BRIEN. Yes, we are. Unfortunately, we have to wait a few years for that. But that is one of our major problems right now; we constantly are bursting at the seams. We have to board psychiatric patients on medicine and surgery in order to take care of them, because we simply don't have enough beds at our hospital for psychiatric patients.

Mr. STEINBERG. Dr. Boudewyns, do you have any comment on the service-connected nature of the population, outpatient or inpatient, at your facility?

Dr. BOUDEWYNS. I am not sure that I have those figures in my head.

Mr. STEINBERG. Could you provide them for us when you go back?

Dr. BOUDEWYNS. Certainly. I could.

Mr. STEINBERG. Do you have anything further to comment on, on that issue?

[No response.]

Mr. STEINBERG. One final question, and that is: Could each of you give us a brief idea of the nature of PTSD treatment that goes on at your facility?

Would you like to start, Dr. Magraw?

Dr. MAGRAW. We have a special program set up for this, but it is an outpatient program. Its characteristic is that we have a set 7-

week recurrent program that goes on about six or seven times a year, an intensive day program, all day, every weekday, for usually 7 to 11 or 12 veterans.

In conjunction with that, we have an ongoing continuing outpatient supportive care program which is both individual and group, and a group for spouses of the participants.

Mr. STEINBERG. Did you say 7 to 10 veterans are involved in the 6 weeks?

Dr. MAGRAW. Yes—for 7 weeks. And that tends to be kind of a case finding. Very few people get permanently and fully improved from that; they have to have ongoing care.

We also have inpatient care provided veterans with PTSD, but it is not a specific program. That tends to be on an ad hoc basis.

Mr. STEINBERG. Are you meeting the demand?

Dr. MAGRAW. It is a very elastic demand. I mean, if you look for PTSD you find it.

Mr. STEINBERG. Well, are you meeting the demand for treatment for schizophrenia? Are you meeting the demand for treatment for other conditions?

Dr. MAGRAW. Mr. Steinberg, those are easy questions to ask but pretty hard to answer. Again, it depends on how you define the "need." We have an awful lot of schizophrenics that are on the street.

We could probably reach more veterans if we had a formal inpatient program.

Mr. STEINBERG. In PTSD?

Dr. MAGRAW. Yes.

Dr. O'BRIEN. Well, I am prepared to say that in Philadelphia I think we are pretty much meeting the demand. We have a multidisciplinary program for PTSD which is based on a philosophy, a theory, that I think needs to be tested—and this is an area that needs a lot of research—that in fact only a minority of PTSD patients really need to be taken away from their environment into an inpatient program. In some cases, as you know, they go on for months.

I am not saying that some patients don't need that, but the majority of them probably don't, and they may do better if they are able to maintain their contact with their families. Some of them in fact are employed.

We have a close relationship with the vet center. We get a lot of referrals from the vet center. And we have a very active program. But it is mainly an outpatient program, where we do individual therapy, desensitization treatment with their traumatic memories, and so forth; they get psychopharmacological treatment, as needed; they have group therapy; we have combat groups; we have prisoner of war groups; we have family therapy.

And when they have a problem—because a lot of these people have a crisis—we will admit them to the hospital, but usually for a short term, 1 to 3 weeks, perhaps.

If we encounter a patient that has a problem that just cannot be handled in this mainly outpatient program, then we get them on the waiting list at Coatesville, which has an inpatient program which is more the traditional long-term program. But at one time it was a 4-month waiting list. So, they are not meeting the need.

But I would submit that maybe not all of those patients really need inpatient care. I think this is a question that needs to be asked, with research, and I don't think we are doing enough research in this area.

We do have a research project on PTSD which is looking at the perhaps biological changes that exist in PTSD patients. They have an increased startle response; they have certain sleep disorders. We have been categorizing their sleep disorders, and we have a project which was won in competitive merit review that we hope will add a little bit to our understanding of what PTSD really is.

But I think that it is one of those areas where the whole field of psychiatry needs information.

Incidentally, it has become the lawyers' favorite, PTSD. Now everybody who is in an automobile accident has PTSD. So I think this is another one of these areas where the VA can help the American society as a whole by studying the patients that we have. A lot of what we learn about these disorders, such as PTSD, can be applied on a wide basis.

Mr. STEINBERG. The program that you describe, the outpatient program, is directed only to PTSD? Or does it involve other conditions as well?

Dr. O'BRIEN. Well, this specific aspect of it is directed only to PTSD.

Now, you have to understand that PTSD is not a pure disorder that only occurs by itself; it is often mixed with other anxiety disorders, with substance abuse—a very, very common mixture—and with other kinds of mental disorders.

So, we take our PTSD patients where we find them. We have some of them in the alcohol program, some of them in the methadone program, some of them on naltrexone, some of them in the cocaine treatment program, and many of them in our mental hygiene clinic.

We have a coordinated effort, though. As I said, it is multidisciplinary. We have psychologists, psychiatrists, nurses, counselors, and social workers working together on these patients, and they meet regularly. They assign the patient to the kind of treatment that he requires. They don't just give everybody the same treatment but tailor the treatment to the needs of the individual patient.

Mr. STEINBERG. Do you have any idea of what the census might be at any given time on PTSD?

Dr. O'BRIEN. At any given time it is maybe 50 to 75 per month, in any given month. You know, I get a monthly report on this.

An interesting thing—I don't know what this means in terms of national trends, but I will report it for what it is worth—in the last few months in Philadelphia we have had a decline in new PTSD patients. So it could be that maybe we are beginning to catch up with the demand. I don't know whether this is an aberration or whether the trend will continue.

But I know that there were a lot of people out there for a long time who had this problem, and who didn't want to have anything to do with the VA. They just suffered with it, didn't know what it was. Then gradually they have been coming out of the woodwork, some of them from back in World War II or the Korean war. It is interesting; it is not just the Vietnam era veteran.

But maybe we are beginning to catch up with those, because there has to be a finite number out there. And it could be that, because of our efforts, eventually we are going to see the end of this, because I consider this to be a treatable disorder. We make a lot of progress with these people. You know, they don't all get cured so that they never have a problem again, but they get substantial improvement. Some of them, for all intents and purposes, do look to be cured.

But in any case, as you begin to get them into treatment and get them out again, perhaps you end up catching up with the demand out there.

Mr. STEINBERG. Thank you. Dr. Boudewyns?

Dr. BOUDEWYNS. I would just like to underscore the point that Dr. O'Brien made about PTSD really being manifest in many other kinds of problems, especially addiction.

At Augusta we have 1 of the 14 special PTSD treatment units that was set up by Congress some 4 years ago, and we see those patients that are very chronic and have other serious social problems, cognitive problems, emotional and addictive problems. So we do need time to work with these patients.

We have a 12-week program, which is about average for those types of units, and we find that it is difficult to manage that program under the RAM. In fact, we have to "make our money," so to speak, using the outliers.

If we can get past like the 45th day, then actually there is an increase in funding on an outlier basis. And if we can keep our staff-to-patient ratio at say under 0.5 or 0.4, then we can survive in the RAM. But if we were to go about our business in the way that it is supposed to be done, where we would discharge these patients after 20 or 23 days, I don't think we would have a program at all.

There has been some research to indicate that the average time for a PTSD in these special treatment units, for these more difficult patients, should probably be around 49 days. And I would hope that that recommendation would come out of the Washako Commission and that they would put that into the RAM.

I have lots of other things to say about PTSD, since it is my area of research, but maybe I shouldn't.

Mr. STEINBERG. Well, if you have a few minutes after the hearing, we may wish to talk with you, since that obviously is a major concern.

We are having a hearing on July 14, as the chairman indicated, just focusing on PTSD, and we would like very much to have the benefit of your experience.

I might also note that at that hearing the General Accounting Office will be testifying with respect to its investigation, which it has carried out at the request of Senator Cranston and Senator Murkowski, of various aspects of the RAM, particularly the RAM in the area of PTSD, drug and alcohol, and long-term psychiatric care.

The comment that you have just made, which we were all smiling at, about how to manage some of your treatment under the RAM, is one on which we congratulate you on your perceptiveness in understanding, because it is quite clear—at least, we think, from what the GAO has found and reported to us preliminarily—that there are many stations which have reduced lengths of stay in order, they believed, to benefit under the RAM in these areas, but only with the result that they have actually reduced their reimbursement rather than increased it, because of the phenomenon that you cite. It isn't even clear in all cases that they know that that is the effect.

But we will be getting into that in greater detail on July 14.

Dr. BOUDEWYNS. It is an interesting issue, and one where I have had some interesting discussions with the administrators of the VA there about that, because there are some assumptions that you should probably stay at that mean; but in fact, for these types of programs, you can do it a little differently, and it works better.

Mr. STEINBERG. If you do have any time to remain afterward, or we can be in touch with you by telephone, we would like to have the benefit of your PTSD experience.

Dr. BOUDEWYNS. I have a plane to catch, but I will be glad to talk to you.

Mr. STEINBERG. We will be in touch with you.

Again, we thank all of you. You have been very generous with your time, and we appreciate your traveling here from around the country.

Dr. Winship, we appreciate your willingness to participate, as well.

We will now have our last panel of the veterans' service organizations. While they come forward, I am going to excuse myself for 1 minute. We will resume with their testimony.

[Pause.]

Mr. STEINBERG. We welcome our last panel this morning: Mr. Ronald Drach and David Gorman of the Disabled American Veterans; Mr. Frank DeGeorge of the Paralyzed Veterans of America; Mr. Samuel Walsh of the American Legion; and Mr. James Magill of the Veterans of Foreign Wars of the United States.

I am tempted to remark, as a past chairman of this committee is wont to do, "Well, here we are again." [Laughter.]

I want to express the appreciation of the committee to each of you for bearing with us through such a lengthy hearing this morning. We found it very profitable and educational, and we hope that it has been that for you as well. We hope to learn still further from your testimony.

And Mr. Philip Wilkerson, my apologies for not welcoming you. We are delighted to have you with us, as always, and we would appreciate it if the Legion would start.

So, Phil, if you would, lead off.

STATEMENT OF SAMUEL J. WALSH, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, AND PHILIP R. WILKERSON, ASSISTANT DIRECTOR, NATIONAL VETERANS' AFFAIRS AND REHABILITATION COMMISSION

Mr. WILKERSON. Thank you very much.

The American Legion appreciates this opportunity to offer to comment on the several legislative proposals, the subject of this hearing.

Among the provisions of S. 2462, The American Legion wishes to express strong support for the extension of eligibility for readjustment counseling to veterans of World War II and Korea as well as those who served after May 7, 1975, in hostile actions.

With respect to the several proposals to improve and expand the VA's ability to recruit and retain health-care professionals, we are cognizant of a nationwide shortage of health professionals and the VA's continuing problems in the area of recruitment and retention of those with needed skills, particularly registered nurses.

We believe the initiatives authorized will enable the VA to address many of the problems in this area, and at the same time provide useful data on further steps that may be necessary.

The American Legion has been a strong supporter of the efforts of the Chief Medical Director's Special Committee on PTSD and strongly endorse the requirement for additional reports by this committee in both 1990 and 1991.

S. 2463 would authorize the establishment of five mental illness research, education, and clinical centers. These would be modeled after the GRECC Program, and funding would be authorized through 1992.

We believe there is a demonstrated need to improve and expand the VA's capability to respond to the needs of veterans suffering from mental illness; however, in light of the problems experienced in the development of the GRECC Program due to inadequate resources, we are concerned that similar difficulties may eventually be experienced by the MIRECCs unless provision is made to ensure continued funding.

The American Legion would view with favor the proposal contained in S. 2207 and S. 2511 to provide, either by statute or under a pilot study, assistive animals to certain severely disabled veterans.

We also support S. 2246, which would authorize respite care for certain chronically ill veterans.

These proposals represent innovative and cost-effective approaches to caring for disabled veterans in noninstitutional settings.

With respect to the operations of the voc rehab program, we believe that the VR&C service is doing a very commendable job in assisting disabled veterans. However, we believe there are a number of factors which have adversely affected both the quality and timeliness of service being provided.

The VA's own data shows that under current staffing levels there has been a substantial increase in the number of days required to complete each phase of the voc rehab process. Because of additional workload responsibilities, the average number of cases handled by an individual counselor has increased from 170 to 181.

Training for the professional staff has been curtailed due to budget restrictions.

Limitations in the available ADP equipment make payment of chapter 31 participants extremely slow.

The American Legion is particularly concerned that, under these circumstances, the VR&C service cannot fully provide the necessary types of employment assistance to assure suitable employment is obtained and retained.

S. 2459 proposes to extend the temporary program of voc rehab and training for certain pension recipients until 1990.

From the results reported, it appears to be accomplishing its intended purpose; however, we are concerned that it has in some degree contributed to the problem of timeliness and quality in the chapter 31 program and can only offer limited qualified support for this measure.

With respect to S. 2464, we support both of the proposals to improve the benefits under the insurance program.

Mr. Chairman, that concludes our statement.

[The prepared statement of Mr. Walsh and Mr. Wilkerson appears on p. 303.]

Mr. STEINBERG. I want to apologize for not recognizing Sam Walsh and welcoming him before.

Sam, do you have anything that you wish to add? Or do you want to make your introduction after the fact?

Mr. WALSH. We have it all taken care of between the two of us, and he handled it for us. Thank you, Mr. Steinberg.

Mr. STEINBERG. Thank you very much.

Now we will hear from the Disabled American Veterans. We welcome Ron Drach and Dave Gorman, old friends.

Dave, would you like to lead off?

Mr. GORMAN. I would.

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Steinberg.

Just a comment, I think. I agree with your comment that the hearing this morning, what we heard from it and the wealth of testimony presented, was certainly beneficial. We were particularly interested in the last panel that testified, and we look forward to appearing before the committee on July 14 with respect to your PTSD hearing.

If there is no objection, I would like to first present the DAV's comments on the various legislative initiatives at the hearing today, and then relinquish the remainder of our time to Ron Drach, our National Employment Director, to cover our views on the Vocational Rehabilitation Program.

The DAV supports the various measures proposing to extend the VA's authority to furnish treatment and rehabilitative services in community facilities relating to substance abuse disabilities, as well as an extension of the very worthwhile Respite Care Program.

We are also supportive of extending the State Veterans' Home Grant Program.

We appreciate Chairman Cranston's continued recognition of the severe health-care staffing challenges facing the VA, and we are generally supportive of the various proposals intended to remedy that situation.

The DAV can support extending eligibility for readjustment counseling services, as contemplated by section 2 of S. 2462. While supportive of the intent of S. 2463, we ask, as we outlined in our written testimony, that careful consideration be given by the committee relating to our concerns about funding of the mental illness research, education, and clinical centers.

Finally, we would also request the committee's consideration of further amending section 628(a) of title 38 to include POW's in the category of veterans, who the VA may consider for reimbursement of certain medical expenses.

With that, Mr. Steinberg, I would like to turn it over to Mr. Drach for his views on the Vocational Rehabilitation Program.

[The prepared statement of Mr. Gorman appears on p. 321.]

Mr. Steinberg. Ron, we are glad to have you with us.

STATEMENT OF RONALD W. DRACH, NATIONAL EMPLOYMENT DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Drach. I am very pleased to be here today.

At the outset, I would like to thank particularly Senator Rockefeller and Senator Cranston for their strong leadership on Senate bill 999 which, as you know, was recently signed by the President. I believe that that piece of legislation will be widely accepted as the major piece of employment service legislation since Public Law 92-540 in 1972.

I would like to just mention a couple of things on the Vocational Rehabilitation Program.

First, on S. 2459, we would strongly recommend that you withhold any further action on S. 2459 until such time as you receive and review the report that was due about 2 months ago from the Veterans' Administration on the program. I think to do so without that report may be premature, because I think there are some questions that need answering before that program is to be extended.

I would like to comment a little bit on the IG audit, although I am not prepared to discuss it in great detail. I would like to offer that I believe the IG audit was really done by a group of auditors who set out with a predestined decision, and they set out to prove that decision.

It is kind of ironic, I find, that throughout the whole report they didn't cite one example of a successful rehabilitation. It would appear that all of the people that they surveyed were either undeserving or unsuccessful in their attempts to go through the program.

I think Dr. Wyant did mention the Employment Services task force report, and I think you have asked for a copy of that report. That report makes 36 recommendations to improve the program. I think a lot of those recommendations are very viable recommendations, some of which could be done administratively at no cost. And I think we need to take a look at that.

I chair the VA's Advisory Committee on Rehabilitation, and we will be looking at that report next week. I am going to ask the committee to think about accepting some of those recommendations, as recommendations of our own to submit to the Administrator.

I am also going to appoint a task force of the Rehabilitation Advisory Committee to take a look at the IG report, with a view toward offering additional comments to the Administrator and to the committee, if they so desire.

The task force report, also, I should emphasize, was done by professionals in the field of rehabilitation, people who know what rehabilitation is about and know what the law and the regulations require. The only ax they have to grind, I believe, is one intended to improve services to disabled veterans, not one that is designed to cut down the program or lessen the effects of the program.

Thank you very much.

[The prepared statement of Mr. Drach appears on p. 337.]

Mr. STEINBERG. Thank you very much, Ron, and thank you for your very kind words about S. 999.

Certainly, we have to extend the same congratulations to you for all of the efforts that you made and all of the efforts that each of the organizations before us made in order to bring about enactment of that legislation, which did take quite a lot of time in the cooking but hopefully will be worth it in the tasting.

Before I go to Jim Magill, I wanted to ask Dr. Wyant, who has been kind enough to still be with us, if we have any indication, Dennis, as to when that report on the Vocational Training Program will be forthcoming.

Dr. WYANT. It is under interagency review right now, and we call on it daily, and we are trying to expedite it. It should be any day now, unless there are some major changes.

Mr. STEINBERG. Since the Administration is proposing, as was indicated in your testimony, a 3-year extension of the program, it would seem to be very much in the interest of the Administration to get that report to us so that we could have a basis for making a judgment about those two different alternatives.

So we would appreciate it if you would convey to the other agency the committee's interest in getting that report as soon as possible.

Dr. WYANT. Thank you.

Mr. STEINBERG. Jim Magill, from the Veterans of Foreign Wars, we would like to have your testimony.

STATEMENT OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. MAGILL. Thank you very much for the opportunity to present the views of the Veterans of Foreign Wars.

Inasmuch as we have heard basically all of the provisions of the various bills, I will not go back and repeat them; but I would just like to make a couple of comments on a couple of areas where we think a little bit more attention should be given.

While we, of course, support extending the Alcohol and Drug Abuse Treatment Program, as we testified to a couple of weeks ago, I would like to again voice our recommendation that this program be made permanent.

We view it as a vital and crucial program, and we think that the need is going to be with us for a long, long time.

Mr. STEINBERG. If I might interrupt you, Mr. Magill, as you recall, at the hearing in his opening statement Senator Cranston did indicate that that was his view, at this time, after having had an opportunity to review the report on that program.

Mr. MAGILL. Yes, sir.

With respect to S. 2419, the VFW does not support eliminating the Administrator's authority to establish the VA home loan interest rate.

We also do not support repealing certain requirements on manufactured homes, nor do we favor repeal of the requirements regarding that the State make feasibility accounting for public water and waste disposal for newly constructed homes.

With respect to respite care, the VFW strongly supports this compassionate and, again, vital program, and we certainly support extending it. Once again, we would recommend that it be made a permanent program.

With respect to S. 2207 and, of course, S. 2511, we strongly support this innovative concept. We believe this action could be of great benefit to this Nation's quadriplegic veterans.

As for making this a pilot program, to be quite frank, at this time we are going to have to defer to the wisdom of the committee. I would like to comment, though, that we do applaud the introduction of these two bills.

We do support all of the other provisions and bills that are before us now.

With respect to VA's Vocational Rehabilitation Program, you have got our own recommendations in our prepared statement. I would just comment that for the most part we think the program is doing quite well. We have had indication that there is an extremely high caseload and that there needs to be more staffing at the program.

This concludes my remarks.

[The prepared statement of Mr. Magill appears on p. 368.]

Mr. STEINBERG. Thank you very much, gentlemen, and thank you for being so concise and precise.

We will now have our last witness, who received some earlier mention, so we thought it only fair that he would take up the cleanup slot. This is Mr. Frank DeGeorge of the Paralyzed Veterans of America.

STATEMENT OF FRANK R. DeGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. DEGEORGE. Thank you both, Mr. Chairman and Mr. Steinberg.

I want to just briefly express my appreciation on my son's behalf and that of our family. We think he will do good. Thank you all for your comments; we appreciate it, again.

Regarding the testimony today: PVA is most pleased that Chairman Cranston has introduced a bill to provide assistive animals to certain veterans with specific disabilities. We commend both Senator Cranston and ranking member Senator Murkowski for their leadership in bringing this important issue for review before the full committee.

I would like to say at this time it is our desire to assure that these legislative proposals are given full and complete evaluation; therefore, PVA wishes to currently have our medical and research affairs department review the bills before we make further comment.

It is perfectly obvious that the committee has taken up many of the concerns and views of the Paralyzed Veterans of America here today; so, with all due respect to my colleagues and to the committee, I will offer no further comments on our testimony at this point and submit it for the record.

Thank you, sir.

[The prepared statement of Mr. DeGeorge appears on p. 382.]

Mr. STEINBERG. Thank you very much, Frank, and thank you to each of you.

There are just a couple of questions.

We were wondering whether any of you had any observations on the matter of the standing of the chapter 31 program within the Department of Veterans' Benefits and the priorities that that Department provides, since the time that the education service and the rehabilitation service have been merged. Do you think there is any perceptible change? That it has made any difference in any respect, or any view that you wish to give us on that issue?

Ron, would you like to lead off?

Mr. DRACH. I haven't seen any discernible difference other than the fact that Dennis himself, personally, probably does not have an opportunity to spend as much time on vocational rehabilitation as he did before when he headed up the one service.

But I have found in my dealings with Dennis and the staff that primarily deals with vocational rehabilitation—Jeff Judson and some of the others, Jim Reed, particularly—are always accessible and available to me to answer any questions I may have.

I think they are doing a pretty admirable job, considering some of the restraints and constraints that they are functioning under.

Mr. STEINBERG. Do others of you have any comments on that issue, on the impact of the merger of the two services? Frank?

Mr. DEGEORGE. No.

Mr. STEINBERG. Jim?

Mr. MAGILL. No.

Mr. STEINBERG. Phil?

Mr. WILKERSON. No.

Mr. DEGEORGE. Excuse me, I would add one. I think we are all aware of the attributes that Dennis Wyant brings to veterans issues and activities, so I would like to say that we are perfectly comfortable with the leadership of Dennis in assuming those two positions.

Mr. STEINBERG. Good. Thank you very much.

Mr. DRACH. Mr. Steinberg, excuse me. The only other thing I would offer, and I don't think it is necessarily attributable to the merging, is the fact that the staffing, as you are well aware, has continued to dwindle, and he is being asked to do more with less people. That is just very untenable.

Mr. STEINBERG. There is some disagreement among you as to what the future shape and role should be of the vocational training program for pensioners.

As you know, the administration has recommended a 3-year extension and opening the program to past rather than only new pensioners, and the legislation pending that Senators Rockefeller and Cranston and Murkowski offered has proposed only a 1-year extension and no expansion.

We were wondering if each of you might want to comment specifically at this point about the differences in those two approaches.

Frank, would you lead off?

Mr. DEGEORGE. Mr. Steinberg, for one, we have recommended or suggested a 1992 date for expiration of the program. The real truth of the matter is, we would like to see it permanent. We feel the service that has been rendered and the veterans that have been assisted warrant keeping this program ongoing, no matter how many veterans it helps. If it helps only one, it is doing good, and taking a person off the rolls, eventually.

Mr. STEINBERG. I don't think there is much question about that issue; I think the question, however, as raised in the DAV testimony and perhaps one of the other organizations as well, is whether or not there are the resources within VR&S to be able to provide the services that the chapter 31 participants require, as well as those education participants who need counseling, and of course the voc training participants.

In that regard, Senator Cranston raised in his opening remarks his view that there was a need to provide a source, a funding source, for contracting for those kinds of counseling services, particularly for education and for voc training counseling, so that the direct VA resources could be utilized for the chapter 31 service-connected beneficiaries.

Do any of you have any comments on that contract issue that he raised, and also I think that Senator Rockefeller got into somewhat?

Mr. DEGEORGE. I will yield to Ron Drach.

Mr. STEINBERG. Thank you.

Mr. DRACH. I really haven't looked at that specific proposal, but I see a dilemma as it faces the DAV in that we have a general resolution out of our national convention opposing contracting out of services that could be performed by the Federal Government.

Now, if you are going to provide for contracting of services over and above what is already provided, that is one issue. But if you are going to contract out services that are currently being provided by existing staff, that is something totally different.

If you are going to provide additional money, why not provide that additional money directly to the VA to hire more staff and bring staff up to the necessary levels to provide the services inhouse?

Mr. STEINBERG. Well, the principal reason for that is that this committee can't provide additional money, but this committee can, as it did in S. 999, attempt to provide a source of funding out of a particular account, which would make it possible for the contract services to be provided.

We analogized here to two things, in Senator Cranston's statement. One is the extended evaluation contracting, which Dennis testified about earlier has been ongoing since 1987; and the other is the program in S. 999 for work adjustment services.

So it is certainly not the intention to detract from any of the existing resources, but to augment and supplement those resources in ways that would expand the FTE that we are able to get to serve effectively as many veterans as possible.

But do you have any comment, Ron, on the 1 year versus 3 years and on the expansion of the vocational training program?

Mr. DRACH. At this point we don't have a position that would oppose the extension, other than to say that we need to look at whether or not there are enough resources to provide for both. And again, we recommend that no action be taken until such time as the pension report is available for your review and our review. And upon that review, I would like to offer further comment.

Mr. STEINBERG. We hope to have that report shortly, and I would ask the rest of you to comment on that. But isn't it clear from the testimony this morning that there are not sufficient resources?

Mr. DRACH. Oh, yes, I think there are insufficient resources. There is no question about that. Now it is a question of how you are going to allocate those resources and how you are going to provide the additional services, if you are indeed going to expand the program or extend the program.

Mr. STEINBERG. I think our feeling about a shorter term extension is that, although we are very committed to the concept which Frank spoke to, as you all know, we are concerned about this resource question, and I think we would prefer an approach which would allow us and you to monitor the program very carefully, to make sure that the resources are being used as effectively as they might, taking into account all of the program beneficiaries.

Jim and Phil, do you have any comments on this question of 1 year versus 3 years?

Mr. MAGILL. What I would like to comment on is, of course we do support the extension; we think the program is working.

Just off the cuff on this thing right now, I would be reluctant to want to extend the program and not have the resources there, and have the thing possibly do a lot more harm than good.

Once again, I would have to agree with Ron and Frank that I would like to look at the darned report. We agree with you that you have got to make the best use of what you have got; and the question is, now, how do you go about that?

Mr. STEINBERG. Right.

Phil, do you have any comments?

Mr. WILKERSON. Just a couple, Mr. Chairman.

We certainly believe that the priorities should lie with the chapter 31 program. This has been an additional responsibility that has been placed on them without any additional resources.

I think as we expressed in our statement, we would hate to see this thing adversely or further adversely impact on the timeliness factor here, for all concerned. I think we would favor the enactment of a limited extension, rather than locking the Agency into a long-term continuation of this particular program.

With respect to the possible utilization of contract services, although we haven't had a chance to analyze that particular program in detail, and this is my own personal feeling, it would appear to be an acceptable way to approach the problem, since it would be more or less on an individual basis rather than some sort of replacement of existing services now being provided by the vocational rehabilitation service.

Mr. STEINBERG. We will have written questions for you, and we also wish you to know that we will be submitting written questions to the VA based on your testimony and some of the suggestions made in your testimony, and you will receive copies of those.

In the interest of salvaging something of the rest of the day, we won't go into any further questions to each of you, but we appreciate generally the very constructive testimony that each of your organizations submitted. Your views on the legislation which various members of the committee have introduced have been generally supportive and helpful, and we appreciate that very much.

Again, I want to thank you for bearing with us so long.

In that vein, before adjourning I think I would be remiss if I did not also thank the enormous contingent from the VA. If they weren't here, we would be talking to ourselves in this room.

I am sure I am going to leave some people out, but I do want to recognize that throughout this entire hearing the following individuals have been present insofar as we are aware:

Dean Gallin, Don Davis, and Rich Robinson of the General Counsel's Office; and Dennis Wyant and Jim Reed from Vocational Rehabilitation and DVB. I know June Shafer was here for a substantial period of time from DVB as well; and from DM&S we have had, of course, Dr. Errera, who has been with us for the entire hearing, and Dr. Winship, Dr. Regan, Bill Ramsey, Dr. Gianinni—we appreciate her interest and her leadership—and of course Vernice Ferguson, who has borne with us the entire time. And I know that I missed some people, and I apologize for that. But we greatly appreciate your interest and your willingness to stay here throughout the hearing. I think it is very helpful to us and very helpful to the witnesses for you to do that, for them to know that their input is indeed being heard by the Agency.

So we thank you all, and this hearing is adjourned.

[Whereupon, at 2:03 p.m., the hearing was concluded.]

APPENDIX

II

100TH CONGRESS
2D SESSION

S. 2207

To amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to provide assistive simians and dogs to veterans who, by reason of quadriplegia, are entitled to disability compensation under laws administered by the Veterans' Administration.

IN THE SENATE OF THE UNITED STATES

MARCH 23 (legislative day, MARCH 21), 1988

Mr. MURKOWSKI introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to provide assistive simians and dogs to veterans who, by reason of quadriplegia, are entitled to disability compensation under laws administered by the Veterans' Administration.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ASSISTIVE ANIMALS FOR CERTAIN DISABLED VETERANS.

(a) IN GENERAL.—Section 614 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(c) The Administrator may provide simians and dogs specially trained as assistive animals tc any veteran who, by reason of quadriplegia, is entitled to disability compensation, and may pay travel and incidental expenses (under the terms and conditions set forth in section 111 of this title) to and from such veteran's home that are incurred in connection with the veteran becoming adjusted to such simians or dogs, as the case may be.".

(b) CLERICAL AMENDMENTS.—(1) The heading of section 614 of title 38, United States Code, is amended by striking out **"seeing-eye dogs"** and inserting in lieu thereof **"assistive animals".**

(2) The table of sections at the beginning of chapter 17 of such title is amended by striking out the item relating to section 614 and inserting in lieu thereof the following:

"614. Fitting and training in use of prosthetic appliances; assistive animals.".

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II

100TH CONGRESS
2D SESSION

S. 2293

To amend title 38, sections 5002(d) and 5004(a)(4), United States Code, to raise the Veterans' Administration's minor construction cost limitation from $2 million to $3 million and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 18 (legislative day, APRIL 11), 1988

Mr. CRANSTON (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, sections 5002(d) and 5004(a)(4), United States Code, to raise the Veterans' Administration's minor construction cost limitation from $2 million to $3 million and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That chapter 81 of title 38, section 5002(d), United States Code, is amended by striking from section 5002(d) the language "medical facility which is expected to involve a total expenditure of more than $2,000,000," and inserting in lieu thereof the phrase "major medical facility project as defined by section 5004(a)(4)."

SEC. 2. Chapter 81 of title 38, section 5004(a)(4), United States Code, is amended by striking the dollar threshold stated in section 5004(a)(4) "$2,000,000," and inserting in lieu thereof "$3,000,000."

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II

100TH CONGRESS
2D SESSION

S. 2294

To amend title 38, United States Code, and other provisions of law, to extend the authority of the Veterans' Administration (VA) to continue major health-care programs, and to revise and clarify VA authority to furnish certain health-care benefits, and to enhance VA authority to recruit and retain certain health-care personnel.

IN THE SENATE OF THE UNITED STATES

APRIL 18 (legislative day, APRIL 11), 1988

Mr. CRANSTON (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, and other provisions of law, to extend the authority of the Veterans' Administration (VA) to continue major health-care programs, and to revise and clarify VA authority to furnish certain health-care benefits, and to enhance VA authority to recruit and retain certain health-care personnel.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Veterans' Administration Health Care Amendments Act of 1988".

(b) Except as otherwise expressly provided, whenever in this act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 2. Section 620A is amended by striking subsections (e) and (f) in their entirety, and by redesignating subsection (g) as (e).

SEC. 3. Section 629B(c) is amended by striking "1989" and inserting in lieu thereof "1991".

SEC. 4. Section 628(a) is amended by striking the word "found" and all that follows in clause (D) of paragraph (2), and inserting in lieu thereof "a participant in a vocational rehabilitation program as defined in section 1501(9); and".

SEC. 5. (a) Section 632(a) is amended by striking "1989" and inserting in lieu thereof "1994".

(b) Section 632(b)(1) is amended to read as follows:

"(b)(1) To further assure the effective care and treatment of United States veterans in the Veterans Memorial Medical Center, there is authorized to be appropriated for each fiscal year occurring during the period beginning October 1, 1988, and ending on September 30, 1994, the sum of $500,000 to be used by the Administrator for making grants to the Veterans Memorial Medical Center. The sum of $50,000 of these grants shall be used for the education and training of health service personnel who are assigned to the Veterans Memorial Medical Center, the remainder to be used for the purpose of assisting the Republic of the Philippines in the replacement and upgrading of equipment and in rehabilitating the physical plant and facilities of the center.".

SEC. 6. Section 641(a) of title 38, United States Code, is amended by striking "$7.30", "$17.05", and "$15.25" and inserting in lieu thereof "$10.67", "$20.48", and "$20.48", respectively.

SEC. 7. (a) Section 4142(a)(1)(B) is amended by striking the words "medicine, osteopathy, dentistry, podiatry, optometry, or nursing", and inserting in lieu thereof "a field of training or study in direct health-care services".

(b) Section 4143(b) is amended:

(1) By inserting "(i)" before the word "With" in subparagraph (C) in paragraph (3).

(2) By striking the period after the words "leading to such degree" in paragraph (3), subparagraph (C).

(3) By inserting after the word "degree" in the last sentence of paragraph (3), subparagraph (C), the following words: "or, if a license or other credential is required for VA employment, the effective date of such license or credential except that the Administrator may, at the request of such participant, defer such date until the end of the period required for the participant to complete an internship or residency or other advanced clinical training. If the participant requests such a deferral the Administrator shall notify the

participant that such deferral could lead to an additional period of obligated service in accordance with paragraph (4) of this subsection.".

(4) By inserting at the end of paragraph (3), subparagraph (C), the following new clause:

"(ii) No such period of internship or residency or other advanced clinical training shall be counted toward satisfying a period of obligated service under this subchapter.".

(5) By inserting the words "or (3)(C)" in paragraph (4) after "(3)(A)".

(c) Section 4144(b)(4) is amended by inserting the words "or other person who provides direct health-care services" after the word "auxiliary".

(d)(1) The heading of section 4141 is amended to read as follows:

"§ 4141. Establishment of scholarship program; purpose; duration".

(2) The item relating to such section in the table of sections at the beginning of chapter 73 of such title is amended to read as follows:

"4141. Establishment of scholarship program; purpose; duration.".

SEC. 8. (a) Subchapter IV of chapter 73 of title 38, United States Code, is amended by adding at the end thereof the following new section:

"§ 4147. Establishment of tuition reimbursement program.

"(a) Notwithstanding section 4104(4), 4107(c)(2), and 4108 of title 5, United States Code, the Administrator may establish a tuition reimbursement program for nurses appointed under this chapter, and may prescribe regulations for the implementation of such program.

"(b) To be eligible for participation in such a program, an applicant must—

"(1) have accrued one year of current satisfactory service;

"(2) be enrolled or accepted for enrollment in an institution approved by the Administrator in a course of study or training leading to completion of a degree in nursing;

"(3) be free of any obligation under any other Federal program to perform service after completion of a course of study or other training program; and

"(4) meet such criteria as may be set forth in the Administrator's regulations.

"(c) As a condition of reimbursement, a participant must—

"(1) maintain employment as a Veterans' Administration nurse while pursuing an approved course under the reimbursement program;

"(2) successfully complete an approved course under the reimbursement program; and

"(3) agree, in accordance with the Administrator's regulations, to perform a period of obligated service as a Veterans' Administration nurse or in a field related to nursing.

"(d) If a participant fails to either—

"(1) maintain Veterans' Administration employment; or

"(2) successfully complete the approved course under such program;

no reimbursement may be provided and no period of obligated service will be incurred.

"(e) The Veterans' Administration may recover any reimbursements made under this section in the event of a participant's breach of the agreement to perform obligated service.

"(f)(1) The Chief Medical Director may—

"(A) waive the right of the Veterans' Administration to recover under this section, and

"(B) waive any nurse's obligation to provide service, whenever compliance by the participant is impossible due to circumstances beyond the control of the participant or whenever the Chief Medical Director determines that waiver would be in the best interest of the Veterans' Administration.

"(2) Any such waiver must be in accordance with the Administrator's regulations.".

(b) The table of sections at the beginning of subchapter IV of chapter 73 is amended by inserting after the item relating to section 4146 the following new item:

"4147. Establishment of tuition reimbursement program.".

(c) The catchline of subchapter IV is amended to read as follows: "Veterans Administration Health Professional Educational Assistance Program".

SEC. 9. Section 5033(a) is amended by striking "1989" and inserting in lieu thereof "1992".

SEC. 10. Section 201(b) of Public Law 99-576 is amended by deleting "1989" and inserting in lieu thereof "1991".

SEC. 11. EFFECTIVE DATE.—The amendments made by section six shall apply with respect to hospital care, domiciliary care, and nursing home care furnished in State home after September 30, 1988.

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II

100TH CONGRESS
2D SESSION

S. 2394

To amend title 38, United States Code, to authorize the appointment of Veterans' Administration-trained graduates in certain health-care professions or occupations by the Veterans' Administration without regard to civil service hiring procedures.

IN THE SENATE OF THE UNITED STATES

MAY 13 (legislative day, MAY 9), 1988

Mr. CRANSTON (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to authorize the appointment of Veterans' Administration-trained graduates in certain health-care professions or occupations by the Veterans' Administration without regard to civil service hiring procedures.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 4106 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(h) Without regard to subchapter I of chapter 33 of title 5, United States Code, the Administrator, upon the recommendation of the Chief Medical Director, may appoint in the competitive civil service individuals with a recognized degree or certificate from an accredited institution in a health-care profession or occupation who were appointed to and successfully participated in a Veterans' Administration-affiliated clinical education program. In using the authority of this subsection, the Administrator shall apply the principles of preference for the hiring of veterans and other persons established in subchapter I of chapter 33 of title 5".

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II

100TH CONGRESS
2D SESSION

S. 2396

To amend title 38, United States Code, to expand the period considered as the Vietnam era in the case of veterans who served in the Republic of Vietnam.

IN THE SENATE OF THE UNITED STATES

MAY 16 (legislative day, MAY 9), 1988

Mr. MITCHELL (for himself and Mr. CRANSTON) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs.

A BILL

To amend title 38, United States Code, to expand the period considered as the Vietnam era in the case of veterans who served in the Republic of Vietnam.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DEFINITION OF VIETNAM ERA.

Section 101(29) of title 38, United States Code, is amended to read as follows:

"(29) The term 'Vietnam era' means—

"(A) the period beginning February 28, 1961, and ending on May 7, 1975, in the case of a veteran who served in the Republic of Vietnam during such period; and

"(B) the period beginning August 5, 1964, and ending on May 7, 1975, in all other cases.".

SEC. 2. APPLICABILITY.

No person shall be entitled to receive benefits for any period before the date of the enactment of this Act by reason of the amendment made by section 1.

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II

100TH CONGRESS
2D SESSION

S. 2419

To amend title 38, United States Code, to repeal provisions relating to setting the interest rate on guaranteed or insured housing loans to veterans and inspecting manufactured homes purchased by veterans, to modify the procedures for the sale of loans by the Administrator of Veterans' Affairs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 19 (legislative day, MAY 18), 1988

Mr. CRANSTON (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to repeal provisions relating to setting the interest rate on guaranteed or insured housing loans to veterans and inspecting manufactured homes purchased by veterans, to modify the procedures for the sale of loans by the Administrator of Veterans' Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Housing Amendments Act of 1988".

NEGOTIATED INTEREST RATES

SEC. 2. Chapter 37 of title 38, United States Code, is amended by—

(a) striking out section 1803(c) in its entirety and inserting in lieu thereof:

"(c) Loans guaranteed or insured under this chapter shall be payable on such terms and conditions as may be agreed upon by the parties thereto, subject to the provisions of this chapter and regulations of the Administrator issued pursuant to this chapter. These loans shall bear interest at such rate as may be agreed upon by the veteran and the lender: *Provided, however,* That such loans shall bear the same interest rate for the life of the loan.";

(b) striking out in section 1810(e)(1)(C) "permitted pursuant to section 1803(c)(3)(A) of this title";

(c) striking out in section 1811(c)(1) "area, at an interest rate not in excess of the rate authorized for guaranteed home loans or manufactured home loans, as appropriate," and inserting in lieu thereof "area";

(d) striking out in section 1811(d)(1) "not to exceed the rate authorized for guaranteed home loans, or manufactured home loans, as appropriate,";

(e) striking out in section 1819(a)(4)(A)(iii) "permitted pursuant to section 1803(c)(3)(A) of this title";

(f) inserting "and" immediately after the semicolon at the end of section 1819(e)(5);

(g) striking out in section 1819(e)(6) "regulation; and" and inserting in lieu thereof "regulation.";

(h) striking out section 1819(e)(7) in its entirety; and

(i) striking out section 1819(f) in its entirety, and inserting in lieu thereof:

"(f) Loans guaranteed under this section shall bear interest at such rate as may be agreed upon by the veteran and the lender: *Provided, however,* That such loans shall bear the same interest rate for the life of the loan.".

SALE OF VENDEE LOANS

SEC. 3. Section 1816(d) of title 38, United States Code, is amended by striking out paragraph (3) in its entirety and inserting in lieu thereof:

"(3) The Administrator may sell any note evidencing such a loan in order to maintain the effective functioning of the loan guaranty program under this chapter—

"(A) with recourse; or

"(B) without recourse. In order to assure such sales without recourse will maximize the proceeds to the Loan Guaranty Revolving Fund, the Administrator shall—

"(i) consult with a professional financial advisor;

"(ii) review the experience of other Federal agencies that have conducted loan asset sales without recourse;

"(iii) explore such marketing strategies as overcollateralized loans or private reinsurances; and

"(iv) accept bids only when they appropriately reflect the prevailing interest rates and characteristics of the loans.".

REPEAL CERTAIN MANUFACTURED HOME LOAN REQUIREMENTS

SEC. 4. (a) Section 1819(h) of title 38, United States Code, is amended by—

(1) striking out the last sentence of paragraph (1); and

(2) striking out paragraph (2) in its entirety, and inserting in lieu thereof:

"(2) Any manufactured housing unit properly displaying a certification of conformity to all applicable Federal manufactured home construction and safety standards pursuant to section 616 of the National Manufactured Housing Construction and Safety Standards Act of 1974 (42 U.S.C. 5415) shall be deemed to meet the standards required by paragraph (1) of this subsection.".

(b) Section 1819(j) of title 38, United States Code, is amended by—

(1) striking out "refuses to permit the inspections provided for in subsection (h) of this section; or in the case of manufactured homes which are determined by the Administrator not to conform to the aforesaid standards; or where the manufacturer of manufactured homes"; and

(2) striking out "warranty." and inserting in lieu thereof "warranty; or in the case of manufactured homes which are determined by the Administrator not to conform to the standards provided for in subsection (h) of this section; or in the case of a manufacturer who has engaged in procedures or practices determined by the Administrator to be unfair or prejudicial to veterans or to the Government.".

(c) Section 1819(l) of title 38, United States Code, is amended by striking out "the results of inspections required by subsection (h) of this section,".

(d) Section 1819(c)(3) is amended by striking out the second sentence in its entirety and inserting in lieu thereof, "The maximum Veterans' Administration liability under such guaranty shall be limited to an amount equal to the difference, if any, between the total indebtedness and the value of the property, as determined by the Administrator, not to exceed the maximum guaranty on the particular loan. Payment of a claim under such guaranty shall only be made after the filing of an accounting with the Administrator.".

PUBLIC AND COMMUNITY WATER AND SEWERAGE SYSTEMS

SEC. 5. Section 1804 of title 38, United States Code, is amended by striking out section (e) in its entirety.

OFFSET OF TAX REFUND FOR HOUSING LOAN DEBT

SEC. 6. Section 1826 of title 38, United States Code, is amended by—

(a) striking out "No" and inserting in lieu thereof:

"(a) Except as provided in subsection (b) of this section, no"; and

(b) inserting at the end thereof the following new subsection:

"(b) This section shall not apply to the reduction of a refund of Federal taxes by the Secretary of the Treasury pursuant to section 3720A of title 31, United States Code.".

TIME LIMIT FOR HOUSING DEBT WAIVER

SEC. 7. Section 3102(b) of title 38, United States Code, is amended by—

(a) striking out "101 and 1801" and inserting in lieu thereof, "101, 1801, and 1818(a)(2) of this title"; and

(b) Inserting at the end thereof, "An application for relief under this subsection must be made (1) within one hundred and eighty days from the date of notification of the indebtedness by the Administrator to the debtor, or within such longer period as the Administrator determines is reasonable in a case in which the payee demonstrates to the satisfaction of the Administrator that such notification was not actually received by such debtor within a reasonable period after such date; or (2) September 30, 1990, if notice of such debt was provided before October 1, 1988.".

EFFECTIVE DATES

SEC. 8. (a) The amendments made by sections 2, 4, 5, and 7 of this Act shall take effect October 1, 1988.

(b) The amendments made by sections 3 and 6 of this Act shall take effect upon enactment of this Act.

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II

100TH CONGRESS
2D SESSION

S. 2446

To amend title 38, United States Code, to extend for one year the authorization of the Veterans' Administration to furnish respite care to certain chronically ill veterans and to extend the due date for a report on the results of an evaluation of furnishing such care.

IN THE SENATE OF THE UNITED STATES

MAY 27 (legislative day, MAY 18), 1988

Mr. ROCKEFELLER (for himself and Mr. CRANSTON) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to extend for one year the authorization of the Veterans' Administration to furnish respite care to certain chronically ill veterans and to extend the due date for a report on the results of an evaluation of furnishing such care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 620B(c) of title 38, United States Code, is amended by striking out "September 30, 1989" and inserting in lieu thereof "September 30, 1990".

(b) Section 201(b)(2) of the Veterans' Benefits Improvement and Health-Care Authorization Act of 1986 (Public

Law 99–576; 100 Stat. 3254) is amended by striking out "February 1, 1989" and inserting in lieu thereof "February 1, 1990".

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II

100TH CONGRESS
2D SESSION

S. 2459

To amend title 38, United States Code, to extend the period for the temporary program of vocational training for certain veterans' pension recipients.

IN THE SENATE OF THE UNITED STATES

MAY 27 (legislative day, MAY 18), 1988

Mr. ROCKEFELLER (for himself, Mr. CRANSTON, and Mr. MURKOWSKI) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to extend the period for the temporary program of vocational training for certain veterans' pension recipients.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be referred to as the "Veterans' Vocational Training Continuation Act of 1988".

SEC. 2. EXTENSION OF THE PROGRAM PERIOD.

(a) VOCATIONAL TRAINING.—Section 524 of title 38, United States Code, is amended—

(1) in subsection (a)(4) by striking out "January 31, 1989" and inserting in lieu thereof "January 31, 1990"; and

(2) in subsection (b)(4) by striking out "January 31, 1989" and inserting in lieu thereof "January 31, 1990".

(b) PROTECTION OF HEALTH-CARE ELIGIBILITY.—Section 525(b)(2) of such title is amended by striking out "January 31, 1989" and inserting in lieu thereof "January 31, 1990".

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II

100TH CONGRESS
2D SESSION

S. 2462

To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs, to provide certain new categories of veterans with eligibility for readjustment counseling from the Veterans' Administration, to extend the authorizations of appropriations for certain grant programs and to revise certain provisions regarding such programs, to revise certain provisions relating to the personnel system of the Department of Medicine and Surgery, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 27 (legislative day, MAY 18), 1988

Mr. CRANSTON (for himself, Mr. MATSUNAGA, Mr. DECONCINI, and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs, to provide certain new categories of veterans with eligibility for readjustment counseling from the Veterans' Administration, to extend the authorizations of appropriations for certain grant programs and to revise certain provisions regarding such programs, to revise certain provisions relating to the personnel system of the Department of Medicine and Surgery, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE.

(a) SHORT TITLE.—This Act may be cited as the "Veterans' Administration Health-Care Personnel and Programs Act of 1988".

(b) REFERENCES TO TITLE 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 2. READJUSTMENT COUNSELING ELIGIBILITY EXTENSION.

Section 612A(a) is amended—

(1) by inserting "(1)" before "Upon;"

(2) by amending the first sentence of paragraph (1) (as redesignated by clause (1) of this section) to read as follows:

"(A) any veteran who served on active duty during the Vietnam era, or

"(B) any veteran who served on active duty after May 7, 1975, in an area during a period in which hostilities (as defined in paragraph (3) of this subsection) occurred in such area, the Administration shall furnish counseling to assist such veteran in readjusting to civilian life."; and

(3) by adding at the end the following new paragraphs:

"(2) Upon the request of any veteran who served on active duty during World War II or the Korean conflict, the Administrator may furnish counseling to such veteran in overcoming any psychological problems associated with such veteran's service during such period. In furnishing counseling under this paragraph, the Administrator shall place particular emphasis on the needs of those who engaged in combat with the enemy. Such counseling shall include a general mental and psychological assessment to ascertain whether such veteran has mental or psychological problems associated with such veteran's active military, naval, or air service.

"(3) For the purposes of subparagraph (1)(B) of this subsection, the term 'hostilities' means a situation in which members of the Armed Forces were, as determined by the Administrator in consultation with the Secretary of Defense, subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in battle with the enemy during a period of war.".

SEC. 3. CONTRACTS AND GRANTS FOR MEDICAL CARE FOR UNITED STATES VETERANS IN THE REPUBLIC OF THE PHILIPPINES.

Subsections (a) and (b)(1) of section 632 are amended by striking out "September 30, 1989" and inserting in lieu thereof "September 30, 1992".

SEC. 4. APPOINTMENT OF CERTAIN HEALTH-CARE PERSONNEL.

Section 4106 is amended by adding at the end the following new subsection:

"(h)(1) Notwithstanding subchapter I of chapter 33 of title 5, the Administrator, upon the recommendation of the Chief Medical Director, may appoint in the competitive service under title 5 individuals with a recognized degree or certificate from an accredited institution in a health-care profession or occupation who were appointed to and successfully participated in a Veterans' Administration-affiliated clinical education program.

"(2) In using such authority to appoint individuals in such service, the Administrator shall apply the principles of preference for the hiring of veterans and other persons established in subchapter I of chapter 33 of title 5.".

SEC. 5. APPROVAL PERIOD FOR INCREASES IN CERTAIN RATES OF PAY.

Section 4107(g)(4) is amended by striking out "ninety" and inserting in lieu thereof "forty-five".

SEC. 6. DISCIPLINARY ACTIONS AND GRIEVANCES.

(a) Section 4110 is amended—

(1) in subsection (a)—

(A) by striking out "of inaptitude, inefficiency, or misconduct" and inserting in lieu thereof "in disciplinary actions for performance or conduct during tenure with the Veterans' Administration, except with respect to matters described in subsection (f) of this section,"; and

(B) by adding at the end the following new sentence: "The Chief Medical Director may delegate the function of appointing a board to an employee of the Department of Medicine and Surgery who is not involved in deciding whether or not to file charges against the employee and who is not subordinate to any official involved in so deciding.";

(2) in the first sentence of subsection (d), by striking out "suitable" and all that follows and inserting in lieu thereof "that the proposed disciplinary action be sustained or modified within limitations prescribed by the Administrator."; and

(3) by adding at the end the following new subsection:

"(f)(1) An employee against whom disciplinary action consisting of a suspension for fourteen days or less, reassignment or reduction in rank without a reduction in basic pay, reprimand, or admonishment is proposed is entitled to—

"(A) an advance written notice stating the specific reasons for the proposed action;

"(B) a reasonable time to answer orally and in writing and to furnish affidavits and other documentary evidence in support of the answer;

"(C) be represented by an attorney or other representative; and

"(D) a written decision and the specific reasons therefor at the earliest practicable date.

"(2) Actions taken under paragraph (1) of this subsection shall be subject to review under either the provisions of section 4120A of this title, in the case of employees appointed under authority of this title who are members of a bargaining unit recognized under chapter 71 of title 5, or any agency review procedure to be established by the Administrator, in the case of such employees who are not members of such a unit. Any such agency review procedure established by the Administrator shall include—

"(A) an informal review of the decision on the disciplinary action by an official of a higher level than the official who made the decision;

"(B) a prompt decision by such higher level official and a right to formal review by an impartial examiner within the agency;

"(C) a prompt report of the findings and recommendations by the impartial examiner; and

"(D) a prompt review of the examiner's findings and recommendations, together with any comments by the employee and the agency on such findings and recommendations, by an official of a higher level than the official who conducted the review pursuant to clause (A) of this paragraph.".

(b)(1) Subchapter 1 of chapter 73 is further amended by adding at the end the following new section:

"§ 4120A. Grievances and certain disciplinary reviews

"(a)(1) For the purpose of resolving (A) grievances of employees appointed under authority of this title who are members of a bargaining unit recognized under chapter 71 of title 5, or (B) except as prescribed in paragraph (2), disciplinary actions as described in subsection 4110(f)(1) of this title involving such employees, the Administrator shall authorize review of agency actions on grievances or disciplinary actions under the procedures negotiated under the authority of chapter 71 of title 5.

"(2) In any matter, as determined by either party, involving disciplinary actions involving questions of clinical competence, the individual selected to arbitrate the matter must be qualified as an arbitrator and also be qualified as a physician, dentist, nurse, or otherwise qualified, by specialized experience or training or both, in examining and adjudicating health-care issues.

"(b) For the purpose of resolving grievances of supervisors and employees appointed under authority of this chapter who are not members of a bargaining unit recognized under chapter 71 of title 5, the Administrator shall authorize review of agency action on such grievances pursuant to an agency review procedure as described in section 4110(f)(2).

"(c) For the purposes of this section, the term 'grievance' means a matter of concern by an employee appointed under this title (as may be negotiated under authority of chapter 71 of title 5) with respect to his or her employment but does not include matters similar to those excluded from grievance procedures under chapter 71 of title 5.".

(2) The table of sections at the beginning of chapter 73 is amended by adding at the end of subchapter I the following new item:

"4120A. Grievances and certain disciplinary reviews.".

SEC. 7. SHARING OF SPECIALIZED MEDICAL RESOURCES.

(a) Section 5051 is amended by striking out "hospitals" both places it appears in the first sentence and inserting in lieu thereof "health care facilities".

(b) Section 5053 is amended—

(1) in subsection (a)—

(A) by striking out "hospitals" the first place it appears and all that follows through "community" and inserting in lieu thereof "health care facilities and other health care facilities (including organ banks, blood banks, or similar institutions), research centers, or medical schools"; and

(B) by striking out the last sentence; and

(2) in subsection (b)—

(A) by striking out "charge" and all that follows in the first sentence and inserting in lieu thereof "methodology that provides appropriate flexibility to the heads of the facilities concerned to establish an appropriate reimbursement rate after taking into account local conditions and needs and the actual costs to the providing facility of the resource involved."; and

(B) by adding "and to funds that have been allotted to the facility that furnished the resource involved" before the period at the end of the second sentence.

SEC. 8. ASSISTANCE TO PUBLIC AND NONPROFIT INSTITUTIONS AFFILIATED WITH THE VETERANS' ADMINISTRATION TO INCREASE THE PRODUCTION OF PROFESSIONAL AND OTHER HEALTH PERSONNEL.

Subchapter III of chapter 82 is amended—

(1) in section 5091, by inserting "(in collaboration with representatives of the professions, the members of which are currently responsible for carrying out the duties involved)" after "medical personnel, and"; and

(2)(A) by adding at the end the following new section:

"§ 5094. Authorization of appropriations

"There is authorized to be appropriated for the purpose of making grants under this subchapter $5,000,000 for each of fiscal years 1989 and 1990 and $6,000,000 for each of fiscal years 1991 and 1992.";

(B) by amending the table of sections at the beginning of chapter 82 by inserting after the item relating to section 5093 the following:

"5094. Authorization of appropriations.".

SEC. 9. PILOT PROGRAM OF PAY AND PERSONNEL MANAGEMENT PRACTICES.

(a) IN GENERAL.—The Chief Medical Director of the Veterans' Administration shall conduct a pilot program at not less than five Veterans' Administration medical centers during calendar years 1989, 1990, and 1991, in order to determine—

(1) the effects of pay and personnel management practices of the Department of Medicine and Surgery of the Veterans' Administration on the ability of the Veterans' Administration to recruit and retain categories of employees (A) who are qualified to provide direct patient-care services, or services that are incident to direct patient-care services, in Veterans' Administration health-care facilities, and (B) as to which problems of recruitment and retention have arisen; and

(2) whether it is desirable to—

(A) establish programs which foster interdisciplinary professional collaboration and collegial relationships between physicians and registered nurses, and what effects such programs would have on the ability of the Veterans' Administration to recruit and retain registered nurses;

(B) expand the administrative and supervisory responsibilities of the position of Chief of the Nursing Service, where such Chief has the requisite qualifications and experience, to include responsibility for support services and clinical departments other than nursing;

(C) create new alternatives for utilizing the skills and knowledge of registered nurses in furnishing direct-patient care and what effects this change would have on the ability of the Veterans' Administration to recruit and retain registered nurses and the cost of providing care to veterans; and

(D) increase the pay differential for evening and night service to attract adequate numbers of qualified workers to these shifts and, as a result, provide the opportunity for consistent day shift positions.

(b) PILOT PROGRAM.—In conducting the pilot program under subsection (a) the Chief Medical Director—

(1) shall—

(A) at not less than three sites, expand the administrative and supervisory responsibilities of the Chief of the Nursing Service to include responsibility for support services and clinical departments other than nursing;

(B) at not less than one site, establish a collaborative-practice committee involving physicians, nurses, and, as appropriate, other direct health-care personnel;

(C) at not less than one site, significantly increase the pay differential for evening and night service; and

(D) at not less than three sites, implement new alternatives for utilizing the skills and knowledge of registered nurses in the furnishing of direct-patient care; and

(2) may implement changes in personnel management practices as otherwise authorized by law so as to gain information with respect to any of the matters required to be studied pursuant to section 231 of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322).

(c) REPORTS.—(1)(A) Not later than February 1, 1990, the Chief Medical Director shall submit to the Administrator and to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the results of the first 12 months' experience under the pilot program required by subsection (a). The report shall contain—

(i) the evaluation of the Chief Medical Director of the effectiveness of each management practice undertaken in the pilot program on the Veterans' Administration's ability to recruit and retain health-care employees;

(ii) information on the cost factors associated with each such management practice;

(iii) an evaluation of the functioning and productivity of staff involved in such changes;

(iv) in the case of expanding the responsibilities of the Chief of the Nursing Service, an evaluation of the supervision and support provided to all designated departments;

(v) a description of any effects on the quality and timeliness of care provided to veterans; and

(vi) a description of any planned administrative actions, and any recommendations for legislation, that the Chief Medical Director considers appropriate to include in the report on the basis of the results of such pilot program.

(B) Not later than sixty days after receiving the report under subparagraph (A), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives any comments on the report that the Administrator considers appropriate.

(2)(A) Not later than June 30, 1991, the Chief Medical Director shall submit to the Administrator and to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the results of the first twenty-four months' experience under the pilot program required by subsection (a). The report shall contain updates on all information provided in the report submitted pursuant to paragraph (1)(A) of this subsection.

(B) Not later than sixty days after receiving the report under subparagraph (A), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives any comments on the report that the Administrator considers appropriate.

(3)(A) Not later than February 1, 1992, the Chief Medical Director shall submit to the Administrator and to the Committees on Veterans' Affairs of the Senate and House of Representatives a final report on the pilot program required by subsection (a). The report shall contain—

(i) updates on all information provided in the report submitted pursuant to paragraph (1)(A) of this subsection; and

(ii) the Chief Medical Director's final assessment of the pilot program based on thirty-six months of operation.

(B) Not later than sixty days after receiving the report under subparagraph (A), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives (i) any comments on the report that the Administrator considers appropriate and (ii) the Administrator's final assessment of the pilot program based on thirty-six months of operation.

SEC. 10. REPORTS ON VETERANS' ADMINISTRATION PROGRAMS FOR VETERANS WITH POST-TRAUMATIC STRESS DISORDER.

(a)(1) Not later than April 1, 1989, the Special Committee on Post-Traumatic Stress Disorder (hereinafter in this section referred to as the "Special Committee"), established pursuant to section 110(b)(1) of the Veterans' Health Care Act of 1984 (Public Law 98–528; 98 Stat. 2691), shall submit to the Administrator of Veterans' Affairs a report setting forth the Special Committee's evaluation of the results of the study required by section 102 of the Veterans' Health Care Amendments of 1983 (Public Law 98–160; 97 Stat. 994). Such report shall include the Special Committee's—

(A) overall evaluation of the conduct, validity, and meaning of the study;

(B) assessment of the capability of the Veterans' Administration to meet the needs for the diagnosis and treatment of post-traumatic stress disorder (hereinafter in this section referred to as "PTSD") of veterans as estimated in the results of such study;

(C) comments on the Administrator's report on the study; and

(D) recommendations for any further or followup research on the matters addressed in the study.

(2) Not later than thirty days after receiving the Special Committee's report under paragraph (1), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a copy of the report, together with any comments concerning the report that the Administrator considers appropriate.

(b)(1) Not later than February 1, of each of 1990 and 1991, the Special Committee shall submit to the Administrator a report containing information updating the reports of the committee submitted by the Administrator under section 110(e) of the Veterans' Health Care Act of 1984 (Public Law 98-528; 98 Stat. 2693), together with any additional information the Special Committee considers appropriate regarding the overall efforts of the Veterans' Administration to meet the needs of veterans with PTSD.

(2) Not later than sixty days after receiving each of the Special Committee's reports under paragraph (1), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a copy of the report, together with any comments concerning the report that the Administrator considers appropriate.

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II

100TH CONGRESS
2D SESSION

S. 2463

To amend title 38, United States Code, to improve the capability of Veterans' Administration health-care facilities to provide the most effective and appropriate services possible to veterans suffering from mental illness, especially conditions which are service-related, through the designation of centers of mental illness research, education, and clinical activities at up to five of its medical centers, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 27 (legislative day, MAY 18), 1988

Mr. CRANSTON (for himself, Mr. MURKOWSKI, Mr. MATSUNAGA, Mr. DECONCINI, Mr. ROCKEFELLER, and Mr. GRAHAM) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to improve the capability of Veterans' Administration health-care facilities to provide the most effective and appropriate services possible to veterans suffering from mental illness, especially conditions which are service-related, through the designation of centers of mental illness research, education, and clinical activities at up to five of its medical centers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 4101 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(g)(1) The purposes of this subsection are (A) to improve and expand the capability of Veterans' Administration health-care facilities to respond with the most effective and appropriate services possible to the needs of veterans suffering from mental illness, especially from those conditions which are service-related, and (B) to advance scientific knowledge regarding mental illness, especially such conditions, and regarding such needs and the methods of meeting them by facilitating higher quality care for eligible veterans suffering from mental illness, especially from such conditions, through research, the training of health personnel in the provision of health care to such individuals, and the development of improved models of clinical services for eligible veterans suffering from mental illness.

"(2)(A) In order to carry out the purposes of this subsection, the Administrator, upon the recommendation of the Chief Medical Director and pursuant to the provisions of this subsection, shall designate not more than five Veterans' Administration health-care facilities as the locations for centers of mental illness research, education, and clinical activities and (subject to the appropriation of sufficient funds for such purpose) shall establish and operate such centers at such locations in accordance with this subsection.

"(B) In designating locations for centers under subparagraph (A) of this paragraph, the Administrator, upon the recommendation of the Chief Medical Director, shall ensure appropriate geographic distribution of such facilities.

"(C) The Administrator may not designate any health-care facility as a location for a center under subparagraph (A) of this paragraph unless the Administrator, upon the recommendation of the Chief Medical Director, determines that the facility has (or may reasonably be anticipated to develop)—

"(i) an arrangement with an accredited medical school which provides education and training in psychiatry and with which such facility is affiliated under which residents and students receive education and training in psychiatry through regular rotation through such center so as to provide such residents with training in the diagnosis and treatment of mental illness;

"(ii) an arrangement with an accredited graduate school of psychology which provides education and training in clinical or counseling psychology or both and with which the facility is affiliated under which students receive education and training in clinical or counseling psychology or both through regular rotation through an accredited internship program at such center so as to provide such students with training in the diagnosis and treatment of mental illness;

"(iii) an arrangement under which nursing, social work, or other allied health personnel receive education and training in mental health care through regular rotation through such facility;

"(iv) the ability to attract the participation of scientists who are capable of ingenuity and creativity in research into the causes, treatment, and prevention of mental illness and into models for furnishing care and treatment to veterans suffering from mental illness;

"(v) a policymaking advisory committee composed of appropriate mental health care and research representatives of the facility and of the affiliated school or schools to advise the directors of such facility and such center on policy matters pertaining to the activities of such center during the period of the operation of such center; and

"(vi) the capability to conduct effectively evaluations of the activities of such center.

"(3) There are hereby authorized to be appropriated for the basic support of the research and education activities of the centers of mental illness research, education, and clinical activities established pursuant to paragraph (1) of this subsection $3,125,000 for fiscal year 1989 and $6,250,000 for each of the next three fiscal years. The Chief Medical Director shall allocate to such centers from other funds appropriated generally for the Veterans' Administration medical care account and medical and prosthetics research account such amounts as the Chief Medical Director determines appropriate.

"(4) Activities of clinical and scientific investigation at each center established under paragraph (1) of this subsection shall be eligible to compete for the award of funding from funds appropriated for the Veterans' Administration medical and prosthetics research account and shall receive priority in the award of funding from such account insofar as funds are awarded to projects for mental illness.

"(5) The Chief Medical Director shall ensure that research activities carried out through such centers include an appropriate emphasis on the psychosocial dimension of mental illness and on models for furnishing care and treatment to veterans suffering from mental illness.

"(6) The Chief Medical Director shall ensure that useful information produced by the research, education and training, and clinical care carried out through such centers is disseminated throughout the Department of Medicine and Surgery through the development of programs continuing medical and related education provided through regional medical education centers under subchapter II of chapter 73 and other means.".

(b) Effective Date.—The amendments made by subsection (a) shall take effect on October 1, 1988.

(c) Reports.—Not later than December 15 of each of 1989, 1990, and 1991, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under the centers established pursuant to the amendment made by subsection (a). Each such resport shall contain—

(1) descriptions of (A) activities carried out at each center and the funding provided for such activities, (B) the advances made at each center in the areas of research, education, and clinical care, and (C) the efforts to disseminate throughout the Department of Medicine and Surgery useful information produced by such activities; and

(2) the Administrator's evaluations of the effectiveness of the centers in fulfilling the purposes of subsection (g) of section 4101 of title 38, United States Code, as added by subsection (a).

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II

100TH CONGRESS
2D SESSION

S. 2464

To amend title 38, United States Code, to provide authority for payment of interest on insurance settlements, and to permit increased discount rates for insurance premiums paid in advance.

IN THE SENATE OF THE UNITED STATES

MAY 27 (legislative day, MAY 18), 1988

Mr. CRANSTON (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to provide authority for payment of interest on insurance settlements, and to permit increased discount rates for insurance premiums paid in advance.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) of this Act may be cited as the "Veterans Administration Insurance Amendments of 1988".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

AUTHORITY FOR INTEREST PAYMENTS

SEC. 101. (a) Subchapter I of chapter 19 of title 38, United States Code, is amended by adding at the end thereof the following new section:

"§ 727. Authority for payment of interest on insurance settlements

"Under such regulations as the Administrator may promulgate, interest may be paid on the proceeds of participating National Service Life Insurance, Veterans Special Life Insurance, and Veterans Reopened Insurance policies maturing on or after the effective date of this section from the date a policy matures to the date of payment of the proceeds to the beneficiary or, in the case of an endowment policy, to the policyholder. The Administrator may pay such interest only in accordance with a determination that the payment of interest is administratively and actuarially sound for the settlement option concerned. The interest payable shall be at the same rate that is established by the Administrator for dividends held on credit or deposit in policyholders' accounts.".

(b) The table of sections at the beginning of chapter 19 is amended by inserting after the item relating to section 726 the following new item:

"727. Authority for payment of interest on insurance settlements.".

SEC. 102. (a) Subchapter II of chapter 19 of title 38, United States Code, is amended by adding at the end thereof the following new section:

"§ 762. Authority for payment of interest on insurance settlements

"Under such regulations as the Administrator may promulgate, interest may be paid on the proceeds of United States Government Life Insurance policies maturing on or after the effective date of this section from the date a policy matures to the date of payment of the proceeds to the beneficiary or, in the case of an endowment policy, to the policyholder. The Administrator may pay such interest only in accordance with a determination that the payment of interest is administratively and actuarially sound for the settlement option concerned. The interest payable shall be at the same rate that is established by the Administrator for dividends held on credit or deposit in policyholders' accounts.".

(b) The table of sections at the beginning of chapter 19 is amended by inserting after the item relating to section 761 the following new item:

"762. Authority for payment of interest on insurance settlements.".

AUTHORITY TO INCREASE PREMIUM DISCOUNT

SEC. 201. (a) Subchapter I of chapter 19 of title 38, United States Code, is amended by adding at the end thereof the following new section:

"§ 728. Authority for increasing premium discount rates

"Notwithstanding sections 702, 723, and 725 of this title, the Administrator may from time to time adjust the discount rates for premiums paid in advance on National Service Life Insurance, Veterans Special Life Insurance and Veterans Reopened Insurance, subject to the limitation that the discount rates may be set no lower than those authorized under sections 702, 723, and 725. The Administrator may make such adjustments only in accordance with a determination that the adjustments are administratively and actuarially sound for the program of insurance concerned.".

(b) The table of sections at the beginning of chapter 19 is amended by inserting after the new item relating to section 727 the following additional new item:

"728. Authority for increasing premium discount rates.".

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OPENING STATEMENT
SENATOR ALAN CRANSTON, CHAIRMAN
COMMITTEE ON VETERANS' AFFAIRS
HEARING ON OVERSIGHT OF VETERANS' ADMINISTRATION ADMINISTRATION OF CHAPTER 31 OF TITLE 38, UNITED STATES CODE AND ON S. 2462 -- "VETERANS ADMINISTRATION HEALTH-CARE PERSONNEL AND PROGRAMS ACT OF 1988"-- 2463, 2207, 2396, 2446, 2459, 2293, 2294, 2419, and 2464

Good morning and welcome to each of you. At the outset, I want to thank Senator Rockefeller for honoring my request to chair this important hearing. Jay has been an active, contributing member of this Committee ever since coming to the Senate three and a half years ago, and I greatly appreciate his help this morning.

Today's hearing concerns the following:

* S. 2462, the proposed "Veterans' Administration Health-Care Personnel and Programs Act of 1988", a bill I introduced on May 27, 1988, and is cosponsored by Committee members Senators Mitchell, DeConcini, Rockefeller, and Graham.

* S. 2463, a bill I introduced that same day, with the cosponsorship of the Committee's ranking minority member, Senator Murkowski, and Committee members Senators Matsunaga, DeConcini, Rockefeller, and Graham to improve VA care for veterans with mental illness, especially conditions which are service-related, through the designation of centers of mental illness research, education, and clinical activities at up to five VA medical centers.

* S. 2207, a bill introduced by the Committee's Ranking Minority Member, Senator Murkowksi, on March 23, 1988, to authorize the VA to provide certain quadriplegic veterans with specially trained simians and dogs. On Tuesday, I introduced S. 2511, to provide for VA pilot programs to be carried out for 3 fiscal years to furnish assistive monkeys and signal dogs to certain disabled veterans.

* S. 2396, a bill introduced by Committee member Senator Mitchell and myself on May 16, 1988, to expand the period considered as the Vietnam era in the case of veterans who served in the Republic of Vietnam.

* Two bills introduced by Committee members Senators Rockefeller, Graham, and myself on May 27 -- S. 2446, to extend for 1 year the VA's authority to furnish respite care to certain chronically-ill veterans, which Senator Graham has cosponsored, and S. 2459, to

extend for 1 year the temporary program of vocational training for certain veterans' pension recipients.

* Five bills which I introduced at the request of the Administration: S. 2293, to increase the dollar limit on VA construction projects considered minor projects; S. 2294, the proposed "Veterans' Administration Health Care Amendments Act of 1988"; S. 2394, to authorize the appointment of VA-trained graduates in certain health-care professions without regard to civil service hiring procedures; S. 2419, the proposed "Veterans' Housing Amendments Act of 1988"; and S. 2464, to authorize the VA to pay interest on insurance settlements and increase discounts for premiums paid in advance.

Additionally, we will be hearing testimony on the VA's administration of the program of training, rehabilitation, and employment assistance, under chapter 31 of title 38, United States Code, for veterans with service-connected disabilities .

I want especially to express my thanks to today's witnesses for their very supportive testimony on the provisions of the various bills I authored or cosponsored which are before the Committee today. Thanks also for your constructive recommendations for improving them. Again, I thank all witnesses for getting their prepared statements to us in advance. That was very helpful.

My appreciation goes equally to the VA, which had a great number of legislative provisions to take positions on in quite a short period. Your testimony was generally quite constructive and positive, and I appreciate your efforts to be both timely and responsive.

S. 2462

I would like, at this point, to highlight certain of the provisions of S. 2462, which is cosponsored by Senators Matsunaga, DeConcini, Rockefeller, and Graham. This bill has as its basic purpose the continued maintenance and improvement of the VA's ability to meet the health-care needs of our Nation's veterans and their dependents. In view of my very strong concern that we must continue strong efforts to reduce and restrain the Federal deficit, this legislation seeks to find ways to improve VA programs without incurring significant new costs.

RECRUITMENT AND RETENTION OF HEALTH-CARE PERSONNEL

I continue to be very concerned about the VA's shortages of health-care professionals. As a review of a study entitled "1986 Survey of Health Occupational Staff" and a preliminary 1987 Department of Medicine and Surgery report makes clear, the VA's turnover and vacancy rates for various health-care professions are critically high and, in some cases, worsening. Several provisions of S. 2462 are intended to improve the VA's ability to recruit and retain qualified health-care workers.

Pilot Program on Pay and Personnel Management Strategies

Section 9 of the bill -- derived from a provision in section 332 of S. 9 to which the House regrettably did not agree in the conference report on H.R. 2616 -- would require the Chief Medical Director (CMD) to conduct, at not less than five VA medical facilities during calendar years 1989, 1990, and 1991, and periodically report on, a pilot program involving the use of various techniques for enhancing recruitment and retention of health-care personnel within the VA. Thus, in addition to studying the practices required to be studied by section 231 of Public Law 100-322, the CMD would be required to determine the desirability of (a) establishing collaborative-practice committees including physicians, nurses, and other health-care providers as appropriate; (b) expanding the administrative and supervisory responsibilities of Chiefs of Nursing Service to include support services and clinical departments other than nursing; and (c) increasing the pay differential for evening and night service to attract adequate numbers of qualified workers to these shifts and provide the opportunity for consistent day shift assignments. In addition, we have added to this provision a requirement for the CMD to determine the desirability of implementing new alternatives for utilizing the skills and knowledge of registered nurses (RN) in providing direct-patient care and to assess any costs or cost savings resulting from the use of these alternatives.

In these days of scarce resources, I strongly believe the VA must continue to focus its efforts on methods which will cultivate a productive work atmosphere. These provisions are designed to do just that. Management studies have shown that salaries and benefits alone will not attract and retain employees; an environment in which employees feel they are recognized for their contributions and permitted input into the decision-making process is also a significant factor. Key staff within the VA have recognized this -- as evidenced in the following statements made on page 4 in the preliminary July 1987 Task Force Report I previously mentioned:

> Management attitudes and actions can play a crucial role in establishing an environment conducive to recruitment and retention of the scarce category worker. Both tangible and intangible products of management are vital.

1. Collaborative Practice Programs. At 1982 and 1987 Senate Veterans' Affairs Committee hearings which focused on personnel shortages within DM&S, the Nurses Organization of the Veterans'

Administration (NOVA) representatives testified to the need for closer working relationships between physicians and nurses. The fact that this need was brought to the Committee's attention in separate hearings five years apart suggests that the issue has not been resolved within the VA. Furthermore, a preliminary report dated July 1987, entitled "Task Force on Recruitment and Retention of Non-Physician Health Care Workers", page 4, stated "[T]here is much room for improvement among our physician and nursing staff in their attitudes and dealings with each other and with our other health care workers."

Collaborative practice programs foster interdisciplinary professional collaboration and collegial relationships between physicians, nurses, and other direct health-care providers and have been shown to enhance personal job satisfaction for both nurses and physicians. I believe such programs could enhance the work environment for VA health-care employees.

2. Expansion of the Role of the Chief of the Nursing Service. I also believe that the use of alternative management structures could have a beneficial effect upon the recruitment and retention of direct health-care staff. In this regard, I note that nurses are in a key position to participate in the development and evaluation of the quality of support and other health professional services. Because most nursing service chiefs once provided direct patient care at the bedside, they may be in a better position to understand the specific support services required than other administrators who have never fulfilled such a role.

An article in the January 1988 edition of the American Journal of Nursing entitled "Hospitals That Attract (And Keep) Nurses" describes one example of a hospital in which departments other than nursing come under nursing's umbrella: At Henry Mayo Newhall Memorial Hospital in Valencia, California, housekeeping, central supply, admitting, respiratory therapy, and, to some extent, maintenance, all report to nursing, and it was reported that as a result quality of care improved and cost savings were achieved.

The management configuration at virtually all VA medical centers has remained unchanged for many years. A few VA facility directors have attempted innovative management restructuring involving the Chief of the Nursing Service but these attempts have been disallowed or discontinued and no formal study has been done to determine the success or failure of this restructuring on the ability of the facility to recruit and retain scarce health-care professionals or on the ability of the facility to support effective bedside care. The purpose of the requirement to test expanding the role of the Chief Nurse is to ensure that creative management models are developed and implemented and that a scientific evaluation is conducted to determine their benefits or lack thereof. If the VA is to be competitive in the hunt for qualified health-care staff, it must be open and innovative, not hide-bound to the past.

3. Pay Differentials. A study of the effects on recruitment and retention of significantly increasing evening- and night-shift pay differentials is required by section 231 of Public Law 100-322. Because I believe that valid recommendations in regard to this specific program would be difficult to arrive at without a trial period, this bill specifically singles out this study to be included in the pilot program.

Furnishing care in medical facilities is a 24-hours-a-day, 7 days-a-week enterprise and requires scheduling employees to work at times that are generally viewed as undesirable. Because the majority of workers choose to work Monday through Friday during regular daylight hours, employers frequently pay premium wages to attract workers to other shifts or to work at less desirable times. The pilot program required by this provision should analyze whether the VA's current 10-percent pay differential is sufficient and, if not, whether an increase would attract personnel to the less desirable shifts on a permanent basis, making it practical to offer consistent day-shift tours of duty to various employees.

4. New Nursing Models for Furnishing Care. The demand for nurses in the United States is expected to increase as our population ages and health care becomes more complex. Ways must be found to attract persons into the profession, not only to resolve today's shortage but to ensure that adequate numbers of nurses will be available in the future. The literature suggests that many perceive the work of nursing and the environment in which this work occurs as undesirable. Nurses are viewed as having little autonomy and status, and nursing is viewed as a field requiring little educational preparation and knowledge. I believe that the VA can and should take a leadership role in changing these perceptions as well as in actually changing the precepts upon which these assumptions are based. I believe that nurses need to be given the latitude and encouragement to develop and test out new systems and methods to help to bring RNs into the VA as well as provide a high quality of compassionate care to our veteran-patients. This provision is designed to move the VA in that direction, the bill includes a provision, requiring the Administrator to determine the desirability of implementing new alternatives for utilizing the skills and knowledge of RNs in providing direct-patient care and to assess the costs or savings resulting from the use of these alternatives.

Special Salary Rates

Under current law, section 4107(g) of title 38, when the Administrator determines it to be necessary in order to obtain or retain the services of certain personnel employed under the title 5 personnel system who provide direct patient-care services or services incident to direct patient care, the Administrator may increase their rates of basic pay. A request to establish these special pay rates is initiated at a particular VA medical center, submitted to VA Central Office for approval -- a process that can take over 200 days -- and, if approved, sent to the Office of Personnel Management (OPM). In the cases of VA employees employed under title 5, the Administrator is required to notify the President not less than 90 days prior to the effective date of the proposed increase. The President or his designee has that 90-day period to disapprove of the Administrator's action and, if the President or his designee disapproves, must notify the appropriate committees of the Congress of the reasons for such action. I am concerned that in some cases the delays which result from this 90-day notice-and-wait period may unwisely hinder the VA's efforts to furnish quality care for veteran-patients.

In order to speed up the approval process and provide relief to VA health-care workers and veteran-patients, section 5 of S. 2462 would reduce -- from 90 days to 45 days -- the amount of time given the President to disapprove the Administrator's decision to provide a rate increase. A review done by the Director of the VA's Office of Personnel and Labor Relations showed that the average time required by the President's agent, OPM, for approval was 42 days and the median time was 33 days. Also, OPM has never disapproved any special-rate authorizations proposed by the VA under section 4107(g).

Appointment of VA-Trained Graduates

The shortage of health-care professionals has created a competitive environment in which hospitals and other health-related employers are actively recruiting capable employees. Private-sector employers are "wining and dining" potential applicants and offering immediate employment with very attractive salaries and benefits. The VA is having difficulty keeping up in these latter areas, and the complex, lengthy civil service application and acceptance process adds to the burden. To provide the VA with the means to hire health-care staff expeditiously, section 4 of S. 2462, which is substantively identical to S. 2394 which I introduced upon the request of the Administration, would authorize the Administrator to appoint recent health-care graduates who received their clinical training at VA facilities to positions at those facilities without regard to the civil service application process. In proposing this new authority, neither I nor the Administration intend that principles of the merit process -- or of veterans preference -- be ignored nor that other screening procedures to ensure the hiring of a high quality of personnel be bypassed.

In 1986, VA health-care facilities provided training opportunities for over 105,000 students. At the time of graduation, many of these students turn to the VA as a potential employer. Those who are not covered under the VA's title 38 appointment authority -- that is, generally, health-care personnel other than registered and licensed practical nurses, physicians, and dentists -- are required to complete a process prescribed by the civil service competitive system which is frequently time-consuming and lengthy. However, because the individuals I am referring to have completed a course of education with a practicum at a VA health-care facility, supervisory personnel at the VA have had an opportunity to assess and evaluate the student's work and generally also have had the opportunity to discuss the student's progress with professors and other clinical preceptors, many of whom have VA appointments themselves.

Thus, VA hiring officials in the VA can be expected to know far more about the clinical competencies of these potential employees than they do about applicants who have not had work experiences at VA facilities. In those circumstances, I believe it is appropriate and advisable to authorize the Administrator to waive the usual civil service hiring process. I congratulate the Administration on this beneficial proposal.

Assistance to Public and Nonprofit Institutions of Higher Learning

National health-care personnel shortages periodically can threaten the quality of health care provided in VA facilities. In the early 1970's, when a similar shortage occurred, the House Veterans' Affairs Committee Chairman, the late "Tiger" Teague, and I proposed and Congress, in Public Law 92-541, enacted in 1972 as part of chapter 82 of title 38, subchapter III, "Assistance to Public and Nonprofit Institutions of Higher Learning, Hospitals and other Health Manpower Institutions Affiliated with the Veterans' Administration to Increase the Production of Professional and Other Health Personnel". These provisions provide the VA with the authority to carry out a program of grants to assist in establishing cooperative arrangements among colleges, schools of allied health professions, and other nonprofit health manpower institutions affiliated with the VA in order to coordinate, improve, and expand the training of professionals and technical allied health personnel and assist in developing new health careers, interdisciplinary approaches, and career advancement opportunities, so as to improve and expand the utilization of allied and other health personnel. The VA awarded 135 grants under these provisions.

Section 8 of S. 2462 would authorize the appropriation of $5 million for each of FYs 1989 and 1990 and $6 million for each of FYs 1991 and 1992 for the purposes described in subchapter III and would direct the Administrator, when establishing new careers, interdisciplinary approaches, and career advancement opportunities, to collaborate with the professions the members of which are currently responsible for carrying out those duties.

I believe that, as was the case with respect to shortages in the early 1970's, that greater support to our health personnel schools and colleges must be forthcoming if we are to overcome current health-professional shortages. Several leading nursing schools, for example, have closed their doors as a result of decreased enrollments. At our May 21, 1987, hearing, testimony was given which showed that there was last year a 13.4-percent decrease in nursing school enrollments over the previous two academic years. The trend in nursing school enrollments between 1986 and 1987 showed a further decline. Overall, there has been a 6-percent decrease in nursing school enrollments over this time period, with a 9.8-percent decrease in programs leading to a Bachelor of Science degree; a 1-percent drop in programs leading to an Associate Degree; and a 20-percent drop in diploma enrollments. The latter decline is thought to be a result of closings of hospital-based programs where diplomas are conferred. Additionally, there are also reports that programs leading to other health-care careers are experiencing similar declines.

Several schools of nursing have successfully implemented creative methods for increasing enrollments but they need further funding either to expand their program or to lower costs so that more persons can participate. As an example, the University of San Francisco School of Nursing has a 15-month program whereby a student with a bachelor's degree in a field other than nursing can earn a bachelor of science degree in nursing. "Second-career" students such as these frequently have families or other responsibilities which prevent them from being able to afford the tuition costs and fees required to return to school. Assistance to schools which would allow them to decrease their tuition costs would encourage increased enrollments.

MEDICAL CARE FOR UNITED STATES VETERANS IN THE PHILIPPINES

Since 1948 the United States has provided funds to the Veterans Memorial Medical Center (VMMC) in Manila for the contract care of United States veterans residing in the Philippines who seek care and treatment for service-connected disabilities or who are unable to defray the cost of their care and for grants to assist in the replacement and upgrading of equipment and rehabilitating the plant and facilities of the VMMC. Both the authority to provide for the contract payments and the authority for the $500,000 annual appropriation for the grants expire on September 30, 1989. Section 3 of S. 2462 would extend these authorizations for three years -- through September 30, 1992.

SHARING OF MEDICAL FACILITIES AND EQUIPMENT

Subchapter IV of chapter 81 of title 38, relating to the sharing of medical facilities and information was enacted in 1966 by Public Law 89-785 for the purpose, in part, of improving the care furnished veterans by authorizing the VA to enter into agreements with medical schools, hospitals, and research centers under which the VA could receive or share specialized medical resources which might otherwise not be feasibly available or effectively utilized for veterans or others. Later, in 1979, legislation which I authored, in section 304 of Public Law 96-151, expanded this authority to include sharing arrangements with organ banks, blood banks, or similar institutions. Our current health-care environment has spawned a variety of entities furnishing community health care, and it is sometimes difficult to label or categorize them. I believe that, if the VA is to be able to take full advantage of sharing arrangements, it must have the flexibility to enter into agreements with these new entities or entities which already exist but are providing a different level of care than in the past. Therefore, section 7 of S. 2462 would expand the categories of facilities with which the VA could enter into sharing arrangements so as to encompass any health-care facility.

Current law, section 5053(b) of title 38, requires that these sharing arrangements provide for "reciprocal reimbursement based on a charge which covers the full cost of services rendered, supplies used, and including normal depreciation and amortization costs of equipment." Under section 5011 of title 38, however, reimbursements under sharing agreements entered into between the VA and the Department of Defense must be based upon a mutually agreed upon methodology that provides appropriate flexibility to the heads of the facilities concerned and takes into account local conditions and needs and the actual costs of the health-care resources provided.

A provision in section 7 of S. 2462 would give the Administrator the same flexibility as is authorized in section 5011. In addition, section 7 of S. 2462, also by analogy to the 5011 program, would require that the money paid for the use of an individual VA medical center's facilities or equipment be alotted to that facility.

I believe that these provisions could give VA facilities a better incentive to enter into useful sharing agreements and strengthen their ability to provide health-care to our Nation's veterans.

READJUSTMENT COUNSELING

Section 2 of S. 2462, which is derived from section 301 of S. 1464 as reported by our Committee last September and passed by the Senate on October 16, would make two changes in the statutory eligibility for readjustment counseling. First, the bill would extend readjustment counseling entitlement to veterans of service in hostilities after May 7, 1975, the end of the Vietnam era. Under this change, the Administrator, after consultation with the Secretary of Defense, would determine that service during specific periods of time in specific locations in which U.S. Armed Forces were under hostile fire would be qualifying service for readjustment counseling purposes.

Second, veterans of World War II and the Korean conflict, with a particular emphasis on those who were in combat with the enemy, would also be made eligible for readjustment counseling. In my view, the Federal Government should never allow to go unmet the requests for counseling help from those who have experienced the stress of combat while serving in the Armed Forces.

With reference to this provision, I note the statement of VA Administrator Turnage, during our Committee's March 4 hearing on the VA's FY 1989 budget, when he was describing the VA's recent approach to the Readjustment Counseling Program and said, "But let me suggest one other thing about the attitude we have had. We said, 'Don't only treat Vietnam veterans, treat active-duty types, treat World War II types, treat Korean veterans, or anyone else who needs that kind of help'."

I agree completely with that sentiment and hope that we will be able to gain final enactment of this provision.

DISCIPLINARY ACTIONS AND GRIEVANCES

Section 6 of S. 2462, which is derived from section 324 of S. 9 as reported by our Committee last November, would amend section 4110 of title 38 to provide that the procedures set forth in title 5, United States Code, for the resolution of specified lesser disciplinary actions (admonishments, reprimands, suspensions of 14 days of less, and transfers not involving loss of grade) would be used in cases involving title 38 personnel (including, in the case of employees who are members of recognized bargaining units, the use of a negotiated grievance procedure involving an appeal to an arbitrator). This section would further amend chapter 73 of title 38 so as to create, in title 38, a grievance-resolution process that parallels that available to title 5 employees.

During our Committee's hearing last year on measures dealing with the VA health-care system and in subsequent activity in follow-up to that hearing, we heard from a variety of sources about problems in the VA's personnel system as it relates to VA health-care employees -- principally physicians, dentists, and nurses -- employed under the VA's title 38 personnel system.

Specifically, both the agency and witnesses representing employee groups raised concerns about the current procedures under section 4110 (the provision under which disciplinary actions involving title 38 employees are carried out), the fairness and timeliness of the overall title 38 personnel system -- especially in contrast to the system under title 5 which applies to other Federal employees, including other VA employees not covered by the title 38 system -- and the ongoing, costly, and time-consuming litigation over issues relating to the relationship between title 5 and title 38 provisions.

In response to those concerns, our Committee reported and the Senate passed section 324 of S. 9. The overall impact of certain of the changes proposed in that legislation and now in S. 2462 would be to make parallel to personnel procedures available to title 5 employees the VA's procedures for disciplinary actions involving title 38 employees where a specified lesser form of discipline is proposed, as well as the VA's procedure for resolution of grievances.

As I noted earlier, this measure would amend section 4110 of title 38 so as to remove from the coverage of that section disciplinary actions involving lesser proposed penalties -- specified as suspension for 14 days or less, reassignment or reduction in rank without a reduction in basic pay, reprimand, or admonishment. All other disciplinary actions would remain covered by the current section 4110 process. This approach, of specifying those matters which would be excluded from coverage, was adopted so as to make clear that any matters not specified would remain covered by section 4110. For example, because of the current VA practice of treating any proposal to remove a title 38 employee's clinical privileges as the same as a proposed removal, current 4110 procedures would continue to apply in such cases.

For the disciplinary matters involving lesser proposed penalties, the bill would provide that a title 38 employee would be entitled, in lieu of a 4110 proceeding, to a process which would include (1) advance written notice; (2) a reasonable time to answer; (3) a chance to be represented by an attorney or some other representative; and (4) a written decision, giving reasons for the decision, at the earliest practicable time. These procedures are generally the same as are provided, pursuant to section 7503(b) of title 5, to all title 5 employees in such disciplinary proceedings.

The bill also would provide two methods by which title 38 employees -- depending on whether they belong to recognized bargaining units or not -- could gain a review of a decision on such a specified lesser disciplinary matter or of a decision on a grievance. These methods, which are parallel to the procedures available to title 5 employees, are either, in the case of title 38 employees who are not members of bargaining units, an agency review procedure established by the Administrator or, for those employees who are members of such a unit, a negotiated grievance procedure which would include binding arbitration. In any disciplinary case involving binding arbitration, if the subject matter of the disciplinary action involved a question of the employee's clinical competence, as determined by either party, the person selected under the negotiated agreement to arbitrate the case would have to be qualified as an arbitrator and also be qualified as a physician, dentist, nurse, or otherwise qualified, by specialized experience or training or both, in examining and adjudicating health-care issues. Appeals from an arbitrator's decision to the Federal Labor Relations Authority would be authorized.

The bill would specify that any VA review procedure for proposed disciplinary actions and any grievance resolution regarding title 38 employees who are not covered by collective bargaining agreements would have to include (1) an informal review by a VA official of a higher level than the official who made the original decision and a prompt decision following that review; (2) a right to have the matter reviewed further by an impartial examiner from within the VA who would have to submit a prompt report of findings and recommendations; and (3) a prompt review of those finding and recommendations, as well as any comments the employee or the agency or both wishes to make on the findings and recommendations, by an agency official at a higher level than the one who carried out the first informal review. These procedures are generally similar to ones currently provided by the VA through internal agency guidelines.

POST-TRAUMATIC STRESS DISORDER

Section 10 of S. 2462 would mandate the submission by the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder of three reports -- the first, by April 1, 1989, providing that Committee's evaluation of the results of the study mandated by section 102 of Public Law 98-160 on the prevalence and incidence of PTSD and other post-war psychological problems among Vietnam veterans, and the second and third, due February 1 of 1990 and 1991, respectively, updating prior reviews of overall VA efforts to meet the needs of veterans with PTSD.

The Special Committee, which was established pursuant to section 110 of Public Law 98-528 and is comprised of twelve employees of the

Department of Medicine and Surgery, has carried out a comprehensive review of the agency's efforts relating to PTSD and has submitted four reports to the Administrator setting forth its findings and recommendations. The Administrator has submitted each of these reports to the Congress and, under current law, is required to submit one further report next February.

I have long been of the view that, because of the strong relationship between exposure to combat and subsequent PTSD, the VA must assume a significant leadership role in the diagnosis and treatment of this disorder. Although I believe that the agency has made some significant strides over the years, much more can and should be done, and the Special Committee has a vital role in identifying areas for improvement and in recommending solutions. To this end, the provisions in S. 2462 would ensure that the Committee continues its review and evaluation and continues to report its findings to the Congress.

Today, I am announcing my intention to introduce shortly and propose at our June 29 markup additional legislation related to PTSD. This measure would require the VA to furnish inpatient and outpatient mental health services to Vietnam veterans who the Chief Medical Director or his designee has diagnosed as suffering from post-traumatic stress disorder.

I have long advocated that, inasmuch as PTSD is most often related to service in combat, the VA be the leader in the diagnosis and treatment of this disorder. In the recently released Vietnam Experience Study, the CDC found that 14.7 percent of the veterans who served in Vietnam have experienced combat-related post-traumatic stress disorder at some time since their service and that 2.2 percent of the veterans in the study had this disorder during the month before their examination. These percentages translate to 450,000 and 66,000 veterans, respectively.

These findings are the latest -- and to this point, the most detailed -- findings that some Vietnam veterans have suffered and continue to suffer very significant psychological problems related to their service in Vietnam. Preliminary information from the extensive PTSD study that Congress mandated the VA to carry out 4 years ago and which is being carried out by Research Triangle Institute suggest that the CDC findings are in no way an overestimate of the prevalance of PTSD among Vietnam veterans.

In view of the extent of this problem among Vietnam veterans, I believe that it is fully appropriate and necessary for Congress to direct the VA to provide care and services to veterans diagnosed as suffering with PTSD. The thrust of this legislation would be that, if an appropriate diagnostician concludes that a Vietnam veteran has

PTSD, care would be forthcoming immediately on a priority basis without the need for a formal adjudication of service connection. This may result in some reallocation of VA resources, but any such change in focus so as to better serve the needs of veterans with PTSD seems to me to be fully in accordance with our historic priorities.

S. 2463

S. 2463 would establish Mental Illness Research, Education, and Clinical Centers (MIRECCs) at five VA medical centers. These MIRECCs would improve the VA's ability to provide the most effective and appropriate services possible to veterans suffering from mental illness, especially conditions which are service-related, and advance scientific knowledge regarding mental illness.

On October 20, 1985, the Special Purpose Committee to Evaluate the Mental Health and Behavioral Sciences Research program of the VA, chaired by Dr. Seymour Kety, reported that the VA has not provided adequate resources to mental illness research and treatment. The Kety Committee recommended, among other things, that centers of excellence be established as a cost-effective and rapid way to develop psychiatric research and enhance psychiatric treatment in the VA system. The report noted that the centers would produce new knowledge, provide research training opportunities on a competitive bases for mental health research, and eventually would generate well-trained clinical investigators who could then initiate research projects at other hospitals.

S. 2463 responds to these recommendations by requiring the establishment of five MIRECCs along the lines of the law establishing the VA's very successful geriatric research, education, and clinical centers (GRECCs) program that has been carried for the last ten years or so.

S. 2207

S. 2207 would authorize the VA to provide simians (monkeys) and dogs who are specially trained as assistive animals to any veteran who, by reason of quadriplegia, is entitled to disability compensation.

On June 14, I introduced S. 2511, a bill to establish a 3-year (FYs 1989-91) pilot program to provide assistive monkeys to certain quadriplegic veterans. This pilot program would direct the VA to provide monkeys to not more than 20 veterans who have service-connected disabilities rated 50-percent or more disabling and are quadriplegic. In addition, the program would require the VA to facilitate (through information and matching efforts) the provision of assistive monkeys to not more than 20 non-service-connected veterans with quadriplegia. This additional feature would provide the opportunity for a broader evaluation of the benefits and costs of these monkeys. Priority for the provision of the monkeys, and for the facilitation of their provision, would be required to be given to veterans with service-connected quadriplegia.

The bill would require the VA to conduct, and submit to the Committees on Veterans' Affairs a report on, an evaluation of the pilot program -- including the benefits to veterans of being provided with monkeys, the costs and cost-effectiveness of providing the monkeys, and the views of the Administrator on the relationship between the provision of a monkey to a veteran and the payment to the veteran of an aid and attendance allowance.

Although for a veteran with high-level quadriplegia, who has lost the use of his or her legs and much or all of the use of his or her hands and arms, an assistive monkey could be of great value, the use of such monkeys is novel; a number of questions as to the extent to which and conditions under which they should be provided by the VA. Hence, I believe that it would be best to gain some experience with the use of assistive monkeys in the context of a pilot program before seeking to resolve them in permanent legislation. These issues include, but are not limited to: the demand by veterans for monkeys; the ability of Helping Hands (the only organization which trains and provides the monkeys) to provide the monkeys in the quantity needed to meet that demand; the arrangements that need to be made for the care of the monkeys when the veteran is hospitalized; and the best method for handling a situation in which the placement of the monkey did not work out, from either the veteran's or from Helping Hands' point of view.

The bill would also provide for the establishment of a similar pilot program for the provision of "signal dogs" -- dogs specially trained to help deaf individuals overcome their hearing impairment by alerting them through non-aural means to sounds such as a telephone, fire alarm, doorbell or a child's cry -- if the Administrator resolves a current conflict by deciding that there is no current authority to provide them.

S. 2396

S. 2396 would expand the period considered as the Vietnam era in the case of veterans who served in the Republic of Vietnam. Enactment of this legislation would enable those veterans who honorably served this country in the Republic of Vietnam prior to the present starting date to qualify for certain benefits for which they are now ineligible.

The definition of Vietnam era is now set by statute (section 101(29), title 38, United States Code) as the period from August 5, 1964, to May 7, 1975.

The present starting date, August 5, 1964, coincides with President Johnson's message to the Congress notifying of an attack by North Vietnamese gunboats on two United States Navy destroyers in the Gulf of Tonkin the preceeding day. The end date was originally set by President Ford in a Presidential proclamation and later enacted by Congress.

I think that February 28, 1961, is a better choice for the starting point of the Vietnam era for those who served in the Republic of Vietnam prior to the Gulf of Tonkin incident. This is the date, set forth in Public Law 89-257, after which United States service personnel could accept awards from the Government of the Republic of Vietnam in connection with service in Vietnam. It also begins the Vietnam era for the purposes of the Internal Revenue Service -- relating to the treatment of income for tax purposes for members of the Armed Forces serving in Vietnam in certain circumstances -- and the Immigration and Naturalization Service -- relating to expedited naturalization based on wartime service.

S. 2419

S. 2419 would extend for one year, through July 1990, the eligibility period for participation in the temporary program of vocational training for certain veterans who receive awards of nonservice-connected disability pension. This temporary program began on February 1, 1985, and will terminate on January 31, 1989.

Section 301(a) of Public Law 98-543 amended title 38 to add a new section 524 establishing a temporary program under which a needy wartime veteran who receives an award of non-service-connected disability pension on the basis of actual permanent and total disability -- as distinguished from presumptive disability based on being 65 years of age or older -- and for whom a vocational goal is determined to be feasible is entitled to be provided with a vocational training program consisting of such services and assistance as are necessary, within certain limitations, to enable the veteran to prepare for, gain, and maintain employment. Public Law 98-543 also added a new section 525 establishing a related temporary program under which the VA health-care eligibility of a veteran who becomes ineligible for pension by reason of earned income is thereafter protected for three years.

By all indications these temporary programs are accomplishing what the Congress intended to be accomplished and should be extended for another year in order both to continue to make training available to new pension recipients and to afford the Congress a further opportunity to assess the advisability of making the programs permanent and of possibly making previous recipients of pension awards eligible for the training.

S. 2446

S. 2446, which would extend for one year, to September 30, 1990, the VA's authority to furnish respite care to certain chronically ill veterans and, to February 1, 1990, the date by which the Administrator is to submit a report on the evaluation of the program to the House and Senate Veterans' Affairs Committees.

I have for many years actively supported the VA pursuing cost-effective alternatives to institutional care. On April 30, 1986, I introduced S. 2388, which included a provision authorizing the VA to furnish respite care. A provision derived from this measure and also derived from a provision introduced by Senator Murkowski, on May 13, 1986, and included in S. 2445, was enacted as section 201 of Public Law 99-576.

The purpose of respite care is, in essence, to provide care for the caretakers of chronically ill individuals who without the caretakers' services would likely be institutionalized. Providing care for such a patient at home instead of in an institution is often, many experts contend, better for the patient's overall health and more cost-effective than institutional care.

Current law requires the Administrator to submit to the Veterans' Affairs Committees by February 1, 1989, a report on the Administrator's evaluation of the program. However, the VA has recently advised that data collection for evaluations will not be complete until September 1988 and that additional information necessary for thorough consideration of this matter will not be available until January 1989. Our bill would provide the VA with adequate time to conduct a complete review of this important pilot program before a Congressional decision regarding its future becomes necessary.

Vocational Rehabilitation under Chapter 31 of Title 38, United States Code

The VA's program of rehabilitation and training for service-disabled veterans under chapter 31 reflects the long-standing paramount concern of the Congress for those veterans who have incurred disabilities in the defense of our country. The vocational rehabilitation program for disabled veterans originated with the National Defense Act of 1916 which created rehabilitation benefits and services for veterans of World War I. Subsequently, Public No.

78-16, enacted on March 24, 1943, provided for vocational rehabilitation for disabled World War II veterans. The goal of the World War II vocational rehabilitation program -- which went basically unchanged until 1980 -- was to restore the employability lost by virtue of a vocational handicap which resulted from a service-connected disability.

The vocational rehabilitation program was subsequently extended to disabled veterans of the Korean Conflict in 1950. Peacetime veterans with service-connected disabilities rated at a minimum of 30 percent -- or less than 30 percent for those veterans with a pronounced employment handicap -- became eligible for vocational rehabilitation in 1962. With the enactment of Public Law 93-508 in 1974, all veterans with service-connected disabilities rated at 10 percent or more became eligible for the program if the need for vocational rehabilitation could be demonstrated.

In 1980, Congress enacted the Veterans' Rehabilitation and Education Amendments of 1980 (Public Law 96-466), which I authored in the Senate, to shift the endpoint of the program of vocational rehabilitation from the restoration of a veteran's employability to the next critical step of helping the veteran to attain -- and maintain -- suitable employment and to place a focus on the needs of those with the more serious disabling conditions. The 1980 law required the provision of, among other services, comprehensive evaluation and diagnostic services for each veteran and the development by the VA and the veteran of an individualized written plan of rehabilitation services. In the cases of severely disabled veterans, the law provided for pre-vocational-training services designed to provide a basis for planning a suitable program to improve the vocational rehabilitation potential or independent living status of the veteran and established a program of independent living services for severely disabled veterans for whom a vocational goal was not currently reasonably feasible.

For our Nation's veterans who have returned from their service with disabilities -- both tangible and hidden -- we must have a rehabilitation program that is second to none. As noted by former Administrator of Veterans' Affairs, Max Cleland, Ernest Hemingway once wrote that "life breaks us all and afterward many are strong at the broken places." The extraordinary resolve, particularly of catastrophically disabled veterans, makes so many of them, truly "strong at the broken places".

Our great admiration for and sense of our Nation's special obligations to these veterans caused our Committee, in our March 25, 1988, report to the Budget Committee providing our views and estimates with respect to the FY 1989 budget for veterans' programs, to propose adding 55 FTEE for vocational rehabilitation and counseling programs. Regrettably, as we will learn this morning, there has been a deterioration in the timeliness of vocational rehabilitation services to disabled veterans in almost every aspect of the program ranging from the time it takes to receive initial counseling and testing, to the time it takes for actual job placement. Nevertheless, the Administration has proposed still further cuts in this program in FY 1989.

There are a number of other oversight issues the Committee will be addressing this morning, and I want to focus on just a few of them which deeply concern me. First is the March 1988 audit of the program by the VA's Inspector General, which raises serious questions about the program's employment impact, application of the eligibility criteria, and general administration. For disabled veterans we want only the very best services, and I am not sure that is happening under chapter 31.

Two particular issues regarding the vocational rehabilitation program concern me greatly. First, given the adverse impact that budget constraints appear to be having on the quality and timeliness of vocational rehabilitation services to disabled veterans, I believe we need to provide for expanded use of contract counseling and do so with funding provided through the readjustment benefits account. Section 11(a) of my bill, S. 999, enacted on May 20, 1988, established a program of job-readiness skills development counseling for VJTA participants funded through the readjustment benefits account. This approach would appear to have great promise both for the provision of comprehensive counseling and assessment services to non-disabled veterans participating in GI Bill programs and currently served by VA counseling psychologists and for the vocational training participants so served. At my suggestion, the VA has begun to use its current authority to contract for the provision of evaluations for veterans under chapter 31, but I doubt it is doing so extensively enough.

The IG's audit concluded that the program is not sufficiently effective and is not economically accomplishing its intended purpose of rehabilitating veterans. The findings of this study assert that the reported success rate of the vocational rehabilitation program is significantly overstated and that only about 6 percent of the 27,000 program participants were rehabilitated. Such a low success rate -- if it is an accurate success rate -- certainly does not reflect the intent of the Congress in the restructuring of the vocational rehabilitation program in 1980.

It appears that a major shortcoming has been the failure to provide adequate training and administrative follow-up -- including effective quality controls -- to ensure that the program design under the 1980 legislation is implemented effectively. Despite our strong support for the basic purposes of this program and commitment to the provision of first-class programs of rehabilitation to those rightfully served by it, we cannot ignore such extensive criticisms as those lodged by the Office of the Inspector General against the administration of the program. Thus, we will be following-up vigorously on the issues raised by the IG and the steps being taken to correct deficiencies.

Another important issue relates to contracting for services. VA counseling psychologists and vocational rehabilitation specialists at VA regional offices are working with caseloads -- as I understand it -- that are so large they have become virtually unmanageable. If there exist legitimate and cost-effective opportunities to contract for comprehensive counseling and assessment services to non-disabled veterans who are currently served by VA counseling psychologists, then these opportunities need to be explored.

Finally, I note my great disappointment over the many delays in the VA's conduct of a cost-benefit study and program evaluation of the chapter 31 program that was requested by the Veteran's Advisory Committee on Rehabilitation some 3 years ago. This study was supposed to be completed this year, but will not be completed until 1990, thus delaying until that time the use of the study's findings to improve the chapter 31 program. That's most regrettable.

In general, I am not satisfied with the current status and achievements of the chapter 31 program. The written testimony we've received for this hearing makes clear that the VA has given this program a low priority in all kinds of respects -- from personnel and training resources to automated data processing. I hope this hearing will be a catalyst for ending this neglect and stimulating the establishment of the appropriate high priority which the rehabilitation of service-connected disabled veterans should be afforded.

EDUCATION-BENEFITS ELIGIBILITY PERIOD EXTENSIONS BASED ON ALCOHOL AND DRUG DEPENDENCIES

I also would like to announce that, at our Committee's June 29 mark-up, I will once again be proposing legislation, which the Senate has previously passed on six occasions since 1979, to extend VA education benefits eligibility periods for those who have been prevented from pursuing their educations by alcohol or drug dependencies. With the recent Supreme Court decisions in the Traynor and McKelvey cases, it is now clear that no judicial relief is available. It is up to the Congress to correct this situation. Those decisions have sparked considerable interest in this area, and I am hopeful that we may finally be able to achieve enactment of these constructive provisions.

FUTURE HEARINGS

Two scheduling matters: We have scheduled an August 11 oversight hearing on VA health care. It seems clear that VA medical centers are experiencing very severe funding problems this year. We need to examine carefully the Administration's response to this apparent crisis and the viability of its position, at least up to this point, that no supplemental FY 88 funds are needed.

Second, our PTSD oversight hearing will be held on July 14 not July 7. That will be a very important hearing.

CONCLUSION

I am looking forward to the testimony of each of our witnesses this morning. Once again, I want to express my deep appreciation to Senator Rockefeller for chairing this morning's hearing.

STATEMENT OF SENATOR FRANK H. MURKOWSKI (R-AK)

BEFORE THE COMMITTEE ON VETERANS' AFFAIRS HEARING

JUNE 16, 1988

Good morning, Mr. Chairman. First, I would like to extend a warm welcome to the witnesses scheduled to testify this morning. We thank you for your participation and look forward to learning your views.

We will hear testimony today on a wide range of issues relating to veterans' benefits and services. Specifically, the Committee will focus on vocational rehabilitation issues and legislation which is pending before the Committee relating primarily to veterans' health care.

Vocational Rehabilitation offers one of the best opportunities for veterans disabled while on active duty to return to a fruitful and successful civilian life. Because of its critical importance to those veterans with an unchallenged commitment from the nation, I am pleased that the distinguished Chairman has included this program on the agenda of today's hearing.

I am pleased to have joined in cosponsoring S. 2459 which would extend the pilot program which provides vocational rehabilitation to veterans awarded non-service-connected disability pensions. Surely everyone -- veteran, community and nation -- is better off when veterans have the resources to trade a place on the pension rolls for one on the pay rolls.

It is indeed an honor to have with us this morning Dr. Mary Joan Willard. Dr. Willard has worked diligently to develop a program which trains simians to provide assistance to quadriplegics. She is the Director of "Helping Hands" -- a nonprofit organization which places trained simians with quadriplegics. My staff and I have worked with Dr. Willard and the Paralyzed Veterans of America (PVA) -- who serve as an advocate for greater independence for severely disabled people -- on my legislation. My bill, S. 2207 would authorize the VA to furnish these assistive animals to veterans who because of a service-connected disability are quadriplegic. The PVA believes that this is an important step to further advance the independence of quadriplegic veterans.

I find it most distressing that the VA does not support S. 2207 which would provide proven assistance to quadriplegic veterans. Let me be clear, my bill would simply authorize -- not require -- the VA to provide these assistive animals. According to VA's own statistics, only 2,350 veterans would even been eligible for this benefit. It is difficult for me to believe that the VA would not support such a program for severely disabled service-connected veterans.

I also look forward to hearing the testimony of the nursing organizations who will be testifying on the critical issues of recruitment and retention of registered nurses. One can rarely pick up a newspaper without reading of this very serious problem. The Committee took great strides to improve the VA's ability to recruit and retain nurses by reporting legislation -- which was ultimately enacted into law -- to provide monetary as well as educational benefits to certain nurses. We are going down the right path but much more needs to be done.

I thank you all for your participation. Thank you, Mr. Chairman.

STATEMENT OF
DONALD L. IVERS
GENERAL COUNSEL
VETERANS ADMINISTRATION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JUNE 16, 1988

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the array of legislative initiatives on your agenda today. In that regard, we very much appreciate your introduction and consideration of a number of VA proposals affecting various Agency programs.

Mr. Chairman, one of the bills on which you asked us to testify today, S. 2459, the proposed Veterans' Vocational Training Continuation Act of 1988, would extend the eligibility period from January 31, 1989, to January 31, 1990, for participation in the temporary program for vocational training for certain veterans who receive awards of nonservice-connected disability pension. We support extension of the program, but believe it should be extended for a 3-year period and that participation should be made voluntary. In addition, we believe the legislative provision which now limits participation in this program to veterans awarded pension during the period subsequent to February 1, 1985, should be eliminated to open the program to veterans awarded pension before February 1, 1985. Veterans awarded VA pension have substantial vocational potential and this vocational training program is effective in helping these veterans return to substantial gainful employment.

Expansion of Eligibility -- Readjustment Counseling Services

Section 2 of S. 2462 would expand eligibility for readjustment counseling services both to veterans who served in the Armed Forces after the Vietnam era in combat or comparable situations, and to World War II and Korean conflict veterans. We believe our readjustment counseling program has been an effective one, and one which could benefit veterans who served in areas such as Grenada and Lebanon. Thus we do not object to this aspect of the proposal. However, we do not support the proposed expansion of eligibility to veterans of earlier wars. The premises on which Congress established this program -- recently returned veterans' need for assistance in readjusting to civilian life, service in a war which lacked public support, Vietnam veterans' distrust of VA, VA's reputed inability to relate to the unique problems of the Vietnam veteran -- have no application here. We have no reason to believe that VA medical center-based mental health programs lack the expertise to respond to the needs of prior war veterans. Expansion of the special eligibility for the Vietnam-era Vet Center program to veterans of prior wars is not warranted in our view.

Contracts and Grants -- The Philippines

Section 3 of S. 2462 would extend the VA's authority to provide payment for care to U.S. veterans in the Philippines in the Veterans Memorial Medical Center and to make grants of up to $500,000 annually to the VMMC for replacing and upgrading equipment and rehabilitating its physical plant and facilities. Before and during the Second World War, thousands of Filipinos served in or with the United States Armed Forces in the Philippines. Many of these veterans were casualties of that War. This Country has consistently reaffirmed its moral obligation to provide medical care and treatment for these veterans.

We support an extension of this expiring authority. We would urge, however, that you provide for a five year extension of this authority (rather than the three years proposed) and stipulate that a portion of the grants be used for education and training of health-service personnel at that facility.

Appointment of VA-Trained Health-Care Professionals

Section 4 of S. 2462 would authorize the VA to appoint graduates of affiliated allied health-care education programs to competitive civil service positions without regard to competitive civil service procedures. This section adopts a VA legislative proposal.

Under its statutory health-care education mission, VA trains annually in clinical education programs in our facilities approximately 50,000 students in allied health-care occupations, including pharmacology, occupational therapy, psychology, social work, audiology, speech therapy, dietetics and recreational therapy. Yet, the complicated and often lengthy civil service process discourages many highly-qualified allied health-care graduates of VA-affiliated clinical education programs from taking jobs with the VA. By the time these graduates complete the process for placement on a civil service register and are certified to the VA, other health care employers have often already hired them. As a result, VA loses potential employees who are already VA-trained and whose potential for employment VA is in a position to evaluate. In this regard, currently VA is experiencing staff shortages in many of these positions. This proposal would enable VA, without jeopardizing merit principles, to directly hire graduates of proven competence, who already are familiar with VA methods, without regard to the competitive service certification process. VA's ability to hire these highly-qualified graduates would reduce administrative costs associated with the orientation and training of new employees.

VA favors enactment of this proposal.

Shortening Period for Approval of Special Pay Rates

Section 5 of S. 2462 would shorten the period from 90 days to 45 days during which the Office of Personnel Management (OPM) may disapprove a VA-approved special salary rate for health-care workers appointed under title 5 and/or VA police officers. Section 4107(g) authorizes VA to pay special higher rates to these employees to meet competition from other employers, but prior to implementation VA must first submit the proposed special rate to OPM for its review. OPM then has up to 90 days to disapprove the special rate. The ability to offer competitive pay rates is essential to VA's efforts to successfully recruit and retain these health-care workers. Shortening the OPM review period and therefore allowing quicker implementation of needed special rates will greatly enhance the effectiveness of the VA efforts.

VA favors section 5.

Disciplinary Boards for Medical Personnel

Section 6 of S. 2462 would narrow the situations where disciplinary boards are required for employees appointed under section 4104(1) of title 38. It would also extend union grievance arbitration, available to title 5 employees, to title 38 professionals in recognized bargaining units. Under this proposal, VA could simplify disciplinary procedures affecting title 38 employees in cases where the charges and proposed penalties are less severe.

Currently section 4110 of title 38 mandates a rather cumbersome peer review process for disciplinary actions against non-probationary physicians, dentists, podiatrists, optometrists, nurses, physician assistants and expanded-function dental auxiliaries, for reasons of inaptitude, inefficiency, or misconduct. There is no distinction based on seriousness of offenses. Current procedures involve notice of charges, opportunity for a pre-decision hearing, right to legal representation and post-decision appeal for even the least serious cases, such as a three-day suspension, as well as for the most serious offense, such as removal for patient abuse.

The hearing, required at the request of the employee, is a trial-type adversarial hearing with a verbatim transcript.

The current disciplinary board system has proven to be overly centralized, time-consuming and highly legalistic, with an average case taking in excess of one year to complete. As the volume of disciplinary actions increases, further processing delays are incurred. The effect of the complexity of the current disciplinary board system has been to diminish the use and usefulness of disciplinary actions as a behavior-modifying measure to maintain high standards of patient care in the medical centers. Because the current system uses such large amounts of time and resources, it discourages managers from proposing moderate penalties and thus tends to frustrate the progressive discipline approach.

Section 6(A)(1)(A) of the draft bill would substitute "performance or conduct" for "inaptitude, inefficiency or misconduct" as the basis for major disciplinary actions. This amendment would adopt a VA legislative initiative.

VA favors enactment of this feature of section 6.

Section 6(a)(3) would limit the use of the disciplinary board machinery to cases where the proposed penalties are most serious: removal, suspension of more than 14 days, or demotions involving loss of grade or basic pay. It would exclude all lesser disciplinary actions in agreement with a VA proposal. In addition, the draft bill would retain advance written notice, opportunity to reply, and right to representation for the lesser actions. Also, impartial review would be provided under an administrative appeal procedure or, for bargaining unit employees, under the union grievance procedure discussed immediately below. This expedited procedure would be similar to that which covers these lesser disciplinary actions for title 5 employees. As a result, the volume of section 4110 disciplinary actions would be reduced. Further, lesser disciplinary actions would be less cumbersome and therefore more readily invoked so that progressive discipline would be more feasible.

VA favors enactment of this feature of section 6 with modification to the union grievance procedure as discussed below.

The current bill would provide VA with authority to delegate board appointments, but it does not expressly authorize the delegation of authority to review board recommendations. The right of appeal to the Administrator is retained. We strongly believe any change to the disciplinary board process should clearly enable those cases that remain covered by section 4110 to be more expeditiously resolved, by giving VA the express power to delegate authority to appoint boards and act on board recommendations.

VA favors amending the bill to provide for delegation of both the board appointment and the review authorities.

Section 6(b) would extend the union grievance procedure prescribed by title 5 to title 38 bargaining unit employees to put them on an even footing with title 5 VA bargaining unit employees. This provision would moot the issue of the duty of the VA to negotiate such a grievance procedure under title 5 which is now pending in a major lawsuit. VA supports extending union grievance arbitration, similar to that available to title 5 bargaining unit employees, to title 38 bargaining unit members. However, VA believes that the bill should be amended to clearly place this grievance process under VA's title 38 personnel system so as to preserve the integrity of that system. As currently written, the bill would place title 38 bargaining unit members under the title 5 union grievance process. Bringing the grievance process under title 38 will make a further amendment necessary to give FLRA specific authority to review arbitrators' awards in these title 38 grievances on the same grounds as FLRA reviews arbitrators' awards under title 5. Furthermore, VA strongly favors the requirement that, in cases involving an employee's clinical competence, the arbitrator must be either a health-care professional or have specialized training in examining and adjudicating health care issues.

VA favors enactment of this proposal with the amendments suggested.

Sharing

Section 7 of S. 2462 would authorize a number of amendments to section 5053 to expand VA's authority to "share" specialized medical resources" with certain community providers. Generally these changes would enable VA to enter agreements with "health care facilities" and "research centers" rather than the more limited kinds of facilities currently covered. The bill also would provide greater flexibility in reimbursement methodology. These changes are likely to result in better utilization of specialized resources. In all, we favor the enactment of this provision.

Grants to Affiliated Allied Health Institutions

Section 8 would authorize the appropriation of $5 million in FY 1989 and 1990 and $6 million for each of the following two years for grants to allied health institutions. We have not, however, had sufficient time to assess the impact such a program could have on VA's ability to meet its medical personnel needs. We are not prepared, accordingly, to support the measure at this time.

Pay and Personnel Management Pilot Program

Section 9 would require the Chief Medical Director (CMD) to conduct during calendar years 1989, 1990, and 1991 pilot programs at not less than five VA medical facilities with respect to determining the desirability of implementing various pay and management practices, including those required to be studied by section 231 of Public Law 100-322, relating to the recruitment and retention of registered nurses and other scarce health-care professionals. Specifically, the programs are to include evaluation of: first, at not less than three of the sites, the effects of expanding the administrative and supervisory responsibilities of Chiefs of Nursing Services to include support services and clinical departments other than nursing; second, at not less than three of the sites, the effects of implementing new alternative for utilizing the skills and knowledge of registered nurses in furnishing direct-patient care; third, at not less than one site, the benefits of the establishment of a collaborative-practice committee; and fourth, at not less than one site, the effects of significantly increasing evening and night shift pay differentials. In addition, the bill would require the CMD to concurrently submit two interim reports regarding the progress of the pilot programs to both the Senate and House Veterans' Affairs Committees and to the Administrator. The Administrator would be required, within 60 days of receipt of the CMD's report, to send forth any comments deemed appropriate to both the Senate and the House Veterans' Affairs Committees. The CMD reports would be required to describe the results of the first 12 and 24 months' experience, respectively under the pilot programs and provide: first, the CMD's evaluation of the effectiveness of each management practice undertaken in the pilot program on the VA's ability to recruit and retain health-care personnel; second, information on the cost factors associated with each such management practice; and third, a description of any planned administrative actions and any recommendations for legislation that the CMD considers appropriate, based on the results of the pilot program. In addition, the CMD, not later than June 30, 1992, would be required to concurrently submit a final report to both the Senate and House Veterans' Affairs Committees and to the Administrator. The Administrator would be required, within 60 days of receipt of the CMD's report, to provide appropriate comments to both the Senate and the House Veterans' Affairs Committees. The CMD's report would be required to provide: first, updates on all information provided in the previous report; and second, a final assessment of the pilot program based on 36 months of operation.

In conducting the study of pay and personnel management practices called for by section 231 of Public Law 100-332, the VA must make determinations with respect to the existence of pay compression and possible remedies, increased evening and night differentials and flexible benefits.

VA supports the recognition in S. 2462 of pilot programs as an effective means of conducting this study. VA believes that the study results would be highly conjectural without pilot program authority, which would provide VA with definitive data on which to base its evaluation and recommendations. However, VA recommends a modification. Section 9 of S. 2462 would provide for VA to conduct a pilot program in conjunction with the section 231 study, and would direct the VA to include in the pilot program (1) expansion of the responsibilities of the Chief of Nursing Service, (2) establishment of collaborative practice committees, (3) expansion of the utilization of nurse skills and knowledge, and (4) a significant increase in evening and night pay differentials. In addition, section 9 provides for VA to implement changes in personnel management practices as otherwise authorized by law. VA recognizes the need to evaluate the efficacy of these personnel management practices. VA is, at the present, utilizing some of them in conducting pilot tests, and several others are in the current approval process. Furthermore, VA will be utilizing all the personnel management practices as well as other innovative practices in its pilot testing. VA would, however, modify the bill to provide specific additional authorities for testing methods to ameliorate pay compression and to provide flexible employee benefits. Such a modification would permit VA to conduct pilot programs on these two areas mandated by section 231 of Public Law 100-322. VA currently lacks legal authority for pilot projects in these areas.

At the completion of the testing, VA will evaluate all of the practices utilized. VA is committed to providing the Committee with a full report reflecting that evaluation. In view of this committment, VA further favors amending this section to include a provision repealing the report requirement in section 231, and eliminating the reports called for in subsection (c). VA believes that this full report is an effective substitute for these reporting requirements.

VA Programs for PTSD

Section 10 calls for the special commitee on PTSD established in accordance with P.L. 98-528 to provide a series of reports relating to the study on the prevalence and incidence of PTSD among Vietnam veterans.

The "special committee's" expertise and long involvement in this area certainly makes it important that we continue to benefit from their insight and recommendations. While we would differ regarding the need for legislative action, we do not oppose this measure.

S. 2463 -- "MIRECC'S"

S. 2463 would call for the establishment and operation of up to five VA health care facilities as centers for mental illness research, education, and clinical care (subject to the appropriation of sufficient funds for that purpose.)

It is not clear that VA needs a statutory basis to start up such a program. Also we would oppose language that would require establishing an automatic priority for any category or source of research proposals, as this measure proposes.

S. 2396 -- Expansion of the Vietnam Era

S. 2396 would expand the legal definition of the term "Vietnam era." For purposes of title 38, the Vietnam era is currently defined as beginning August 5, 1964, the date of the Gulf of Tonkin Resolution. The effect of this legislation would be extension of the beginning date to include the period from February 28, 1961 through August 4, 1964, for veterans who served in the Republic of Vietnam during that time. February 28, 1961, is the date after which, pursuant to Public Law 89-257, service in Vietnam and the waters or lands adjacent thereto qualified Americans to receive decorations from foreign govern- ments. Those veterans served under adverse conditions akin to wartime conditions, and should be eligible for benefits for which wartime service, or Vietnam era service, is a requirement. Thus, we favor enactment of this measure.

Veterans covered would become potentially eligible for several benefits. Principally, they could receive nonservice-connected pension benefits if they meet disability, income, and net-worth requirements. Eligibility could also arise for certain burial benefits, vocational counseling, readjustment counseling services, medical benefits under Public Law 97-72, and loan guaranty benefits in certain cases. In addition, survivors of the veterans covered by this provision would be potentially eligible for nonservice-connected death pension benefits if they meet relationship, income, and net worth requirements. Assuming that current Vietnam-era veteran and survivor participation rates would be similar for these potentially new Vietnam-era veterans and survivors, and given that the number of individuals to be affected is estimated to be fewer than 20,000, the estimated cost for these additional benefits is less than $1 million for each of the next five fiscal years with administrative costs of $100,000 for each fiscal year.

Assistive Animals

S. 2207 would amend 38 U.S.C. § 614 to authorize VA to provide simian aides and assistive dogs to veterans entitled to disability compensation for quadriplegia. It also would authorize payment of travel expenses incurred by the veteran in becoming adjusted to the animal.

VA is deeply committed to providing all medical and rehabilitative services needed by service-connected spinal cord injured veterans. In studying this legislation, however, we believe a different approach is needed to properly explore the development and use of animals to assist the severely disabled.

In the area of simian aides, we welcome the progress which has been made in this work, and note that VA is proud to have supported it financially. However there are many practical problems which lie ahead. Some 2,350 veterans receive compensation for loss of use of upper and lower extremities. There is no indication of the availability of significant numbers of trained animals being held for VA placements. Undoubtedly, it would be many years before those seeking such help could get it. Enactment of S. 2207 would surely raise some false expectations. Still more important, the feasibility of home placement and the procedures for training the veteran to use the simian aide have not been proven or developed to serve a national veteran population.

Some of these same questions arise in connection with the proposal to provide specially trained dogs. In that regard, it also bears noting that trained dogs would be of limited use to quadriplegic veterans because of the patient's severe limitations and the limited capacities of the animal.

Mr. Chairman, the use of assistive animals for the catastrophically disabled has appeal. As I noted, Mr. Chairman, the VA has supported the valuable research done on simian aides. We believe it is important to continue to support that particular work. In light of the practical problems we have highlighted in connection with launching a full program at this time we do not support enactment of S.2207. However, we would recommend that the Committee consider the establishment of a pilot program to permit development efforts and testing of the feasibility and effectiveness of providing assistive animals for catastrophically disabled veterans.

Respite Care

Congress authorized VA in Public Law 99-576 to establish a program under which it would provide "respite" care to veterans eligible for benefits under 38 U.S.C. § 610. Authorization for such services expires on September 30, 1989. Respite care allows VA to provide chronically ill veterans who reside athome with brief, planned periods of care in VA facilities in order to provide members of the veterans' families with some relief from the physical and emotional rigors of continuous home care. VA has just begun to gain some experience with respite care. It is expected that this program will help allow veterans to remain at home in the care of their loved ones, rather than requiring them to be institutionalized for protracted periods.

We support an extension of that authority but urge the adoption of our own proposal in S. 2294, which would authorize this benefit for another two years. S. 2446 would only extend the authority for a single year. S. 2294 would also extend by two years the date by which VA must report to the Congress on its evaluation of the new respite care program, allowing for a more thorough and complete analysis of the program's effectiveness. Extension of the respite care program for two years would not result in significant costs.

VA-Initiated Proposals

Mr. Chairman, I will next briefly discuss several bills which you graciously introduced on behalf of the Administration. More detailed comments and explanations of the bills are contained in the packages which were submitted to the President of the Senate with our request that the measures be introduced. One of those bills, S. 2394, is a measure to authorize appointment of VA-trained graduates in certain health-care professions without regard to civil service hiring procedures. Section 4 of your bill, S. 2462, includes the same provision, and our comments on that subject are included in our comments on your bill.

S. 2293 -- Increase in Minor Construction Cost

S. 2293 would amend section 5004 of title 38 to raise the dollar limit on VA construction projects considered to be minor projects. Specifically the bill would change from $2 million to $3 million the dollar threshold by which a VA major medical facility project is, in part, defined. A conforming amendment would also be made in section 5002 which requires the Administrator to consider the sharing of health-care resources with the Department of Defense when projects cost over $2 million. Raising the cost limitation from $2 million to $3 million is necessary as project costs have risen due to inflation. This proposal would not produce any additional costs or savings.

S. 2294 -- Proposed Health Care Amendments Act

In proposing S. 2294, the Veterans' Administration Health Care Amendments Act of 1988," we sought primarily to extend successful VA health care programs, and enhance recruitment and retention efforts. With Public Law 100-322 Congress has already enacted some of these initiatives.

One of the most significant pending provisions of the bill would authorize an extension through Fiscal Year 1992 of the State home construction grant program which provides the States with assistance in the construction or acquisition of State home facilities. The grants make it possible to provide medical care to many more veterans than can receive care in VA facilities. It is a cost-effective program in which Federal participation is limited to no more than 65 percent of the cost of any one project. Funding authority for that program expires on September 30, 1989. Extension of VA's authority now, assuring States of the Federal Government's continued interest in the program, would encourage States to submit grant applications for placement on the July 1, 1989, priority list for Fiscal Year 1990 funds. Extension of this grant program for three years would result in estimated costs of $42.0 million in each of Fiscal Years 1990, 1991, and 1992. These costs are included in the President's budget estimates.

A provision in S. 2294 which would authorize VA to continue its successful drug and alcohol halfway house program was discussed in detail in another hearing before this committee last week.

Two other provisions of the bill would extend VA's respite program, and continue grants to the Veterans Memorial Medical Center in the Philippines. Those measures would also be accomplished by other bills discussed earlier in our testimony, S. 2446, and section 3 of S. 2462. Finally, we would note that the recruitment and retention provisions of S. 2294, which would modify the VA's nurse scholarship program, and would authorize expanded tuition reimbursement, were largely included in the recently enacted Public Law 100-322.

S. 2419 -- Housing Amendments Act

S. 2419, entitled the "Veterans' Housing Amendments Act of 1988," proposes a number of amendments to the Veterans Administration Housing Loan Guaranty Program to reduce administrative regulation and enhance revenues. As a technical matter, we note that section 415 of Public Law 100-322 contained a technical reorganization of chapter 37 of title 38. That law was enacted after S. 2419 was drafted and thus a number of the provisions in S. 2419 refer to the former section numbers. We would be pleased to work with your staff to update this bill.

Briefly summarized, Mr. Chairman, S. 2419 would repeal current provisions of the law requiring VA to set an interest rate on guaranteed housing loans and provide instead that such loans shall bear the rate of interest agreed upon by the veteran borrower and lender. This would permit the transaction to be tailored to fit the needs and circumstances of the parties involved and would allow the veteran greater flexibility in obtaining financing. This is consistent with the Adminstration's goal of reducing Federal regulation and permitting market forces to operate. The bill would also repeal the former section 1816(d)(3) (now section 1833(a)(3)) of title 38 that regulates the manner in which VA may sell vendee loans. It would substitute provisions granting the Administrator flexibility to sell loans in a cost effective manner, either with or without recourse. Administration credit management policies favor selling loan assets without recourse. Selling loan assets with recourse does not accurately measure the Federal subsidy and it creates a contingent liability to the Federal government for the full faith value of the loan. The present law also imposes complex and costly administrative requirements on VA without tangible benefit.

The bill would also amend former section 1819 (now section 1812) of title 38, relating to VA's manufactured home loan program to repeal requirements that VA believes are no longer necessary and reflect changes that have occurred in Federal and State regulation of the manufactured housing industry since the Congress enacted this program.

S. 2419 would also revise the procedures to speed up paying manufactured home loan guaranty claims and prevent an increase in the claim due to depreciation of the unit. It would repeal the requirement (which imposes an added burden on the public without materially benefiting veterans) for a certification regarding water and sewerage systems, a subject other Federal, State, and local laws adequately address. It would also permit VA to collect housing loan program debts by offsetting against the debtor's Federal tax refund, consistent with the policy set in 31 U.S.C. § 3720A. Finally, the bill would impose the same

180 day time limit for a veteran to request waiver of a home loan debt that applies to all other VA debt waiver requests.

S. 2464 -- Proposed Insurance Amendments Act

S. 2464, entitled the Veterans' Administration Insurance Amendments Act of 1988," would make two significant changes in VA's insurance programs. It would first authorize the Administrator to pay interest on policy proceeds from participating National Service Life Insurance (NSLI), Veterans Special Life Insurance (VSLI), Veterans Reopened Insurance (VRI), and United States Government Life Insurance (USGLI), for the period from the date of death to the date of payment or, in respect to an endowment policy, from the date of its maturity to the date of payment. Whether and when interest would be paid in the context of a particular settlement option (i.e., lump sum payment, limited number of monthly installments, or lifetime annuity) would depend on a Veterans Administration determination that such payment is administratively and actuarially sound.

Although claims are generally paid within 10 days from the date of receipt in the VA, in some cases a significant period of time elapses between the date when life insurance proceeds become payable and the date when the actual payment is made. As a matter of equity, at least as to those cases involving substantial delays, interest earned on the proceeds from the date of a policy's maturity until settlement should be distributed to the beneficiary(ies) in death cases, or to the policyholder in matured endowment cases. Payment of interest on settlement proceeds in this manner would be consistent with standard practice in the commercial life insurance industry.

There would be no significant costs or savings connected with this proposal since the effect of paying settlement interest is to shift surplus funds from the annual dividend distribution to the recipients of such settlements. There would, however, be a small impact on dividends.

The second major provision of the bill would authorize the Administrator to adjust the discount rates for premiums paid in advance on NSLI, VSLI, and VRI policies. All premiums, including those paid in advance, become assets of the insurance trust funds after receipt by the Veterans Administration. These funds are primarily invested in U.S. Treasury securities. The difference between the discount rate and the average trust fund yield generates excess earnings, which are currently paid to the policyholders (including those who do not pay advance premiums) through the annual dividend distribution. The effect of this practice, however, is to subsidize the dividends of all policyholders through premiums attributable solely to policyholders who pay premiums in advance.

We believe it would be more equitable to provide a larger discount to policyholders who pay premiums in advance. In addition, increasing the discount rate should encourage some policyholders who now pay their premiums on a monthly basis to switch to a quarterly, semi-annual, or annual basis, with attendant administrative savings for the Government. Under this plan, we would initially increase the premium discount to 7.5 percent, based on actuarial projections that the average trust fund yield will remain at this rate or higher for at least the next eight years.

There are no significant administrative or program costs or savings associated with this proposal. The impact on dividends of an increase in the premium discount rate would be small by comparison to the total dividends.

Mr. Chairman, this concludes our testimony. My colleagues and I would be pleased to respond to any questions you may have.

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

CIRCULAR 10-87-81

August 6, 1987

TO: Regional Directors; Medical District Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: Vocational Rehabilitation Case Management Program and Annual Report (RCS 10-0109)

1. PURPOSE:

a. To establish policies and procedures for the DM&S case management of vocational rehabilitation in the Veterans Administration.

b. To revise the established reporting system of services provided through the case management program, reducing the existing semi-annual report to an annual summary of productivity.

2. POLICY: The VA will provide a case management program and an annual reporting system to cover the program.

3. BACKGROUND:

a. Definition: Case management is defined as an integrated approach to the provision of vocational rehabilitation services which places special emphasis on bringing the full resources of the Veterans Administration and the community to bear on the vocational rehabilitation of disabled veterans.

b. Objectives:

(1) Assure that all eligible veterans are informed of and assessed for necessary vocational rehabilitation services.

(2) Coordinate and expedite the comprehensive services for veterans eligible and in need of vocational rehabilitation services while receiving treatment at a medical center, domiciliary, or outpatient clinic.

(3) Work closely with the ward treatment teams and service providers to develop and complete comprehensive vocational rehabilitation plans.

(4) Work closely with DVB case managers in providing services for service-connected veterans eligible for vocational rehabilitation benefits.

(5) Link with the State Department of Vocational Rehabilitation and other appropriate federal, state and community agencies when indicated for non-service connected veterans.

c. Role of Case Manager:

(1) Develop and maintain a referral procedure with Medical Administration Service (MAS) and/or medical center resources, so that all eligible veterans are screened for and informed of available vocational rehabilitation services.

THIS CIRCULAR EXPIRES ON AUGUST 5, 1988

(2) Orient appropriate treatment teams and service providers regarding the veteran's vocational rehabilitation needs, and enlist their cooperation in providing necessary care and services.

(3) Participate in treatment team and discharge planning meetings in order to develop appropriate rehabilitation plans.

(4) Provide vocational counseling, testing and evaluation, job readiness and placement activities, if such services are available at the local medical center.

(5) Develop and document vocational rehabilitation plans in veterans' treatment record.

(6) Develop, coordinate and expedite the necessary services to successfully complete the veteran's vocational rehabilitation plan.

(7) Serve as liaison to the VA Regional Office for those veterans entitled to training benefits through the VA. Coordinate and facilitate applications for vocational rehabilitation benefits with the Veterans Benefits Counselor at each facility. Keep the DVB Division of Vocational Rehabilitation and Counseling at the Regional Office informed of all relevant services being provided by the medical center staff. Provide assistance, when needed, to DVB for timeliness and availability of medical services to facilitate veteran's involvement with vocational rehabilitation training. Facilitate the transfer of DVB cases to the DVB Counselor upon discharge from the medical center.

(8) Serve as liaison to the State Office of Vocational Rehabilitation and other state, federal and community agencies for veterans.

(9) Provide follow-up for veterans who have participated in vocational rehabilitation activities until the needs identified in the vocational rehabilitation plan have been met or the case has been closed.

4. ACTION:

a. Program Responsibility:

(1) The Director, Rehabilitation Medicine Service, Department of Medicine and Surgery, VA Central Office, has overall responsibility for the Case Management Program.

(2) A VACO-designated Field Advisory Committee, comprised of professionals with a background in vocational rehabilitation, will serve as a council in providing ongoing input with medical centers, domiciliaries and outpatient clinics.

(3) The Center Director of each field station will provide, within existing FTEE, at least one full-time or part-time case manager. The individual designated case manager at the medical center should have a background in vocational rehabilitation and the ability to coordinate interdisciplinary activities. The incumbent should have a working knowledge of the physical, mental, social and psychological aspects of disability, as well as a knowledge of vocational counseling. Exceptions to these qualifications must be reviewed and granted by VA Central Office (117).

(4) While in most facilities, placement of the vocational case management program may be more appropriate under Rehabilitation Medicine Service, it is also understood that this alignment may not be feasible, even inappropriate. Therefore, it is suggested that responsibility for this program, both administratively and programmatically, be designated by local medical center management to that Service(s) which demonstrates the most interest and expertise in vocational case management activities."

(5) Depending on caseload size and range of responsibilities, it may be necessary to select multiple case managers, or additional staff, to assist in the vocational rehabilitation process.

(6) Specific position descriptions, based on overall task expectations defined in the circular, are the responsibility of each facility.

(7) Case managers should have authority to make direct requests for necessary services in order to complete the patient's vocational rehabilitation plan.

b. Evaluation:

(1) Each facility will put in writing the case management process for their station. It will outline the operating procedures, methods, and paperwork to be utilized. The original copy of this written process will be submitted to VA Central Office (117) no later than 90 days after receipt of this Circular.

(2) Evaluation will be ongoing, and periodically monitored. Site visits may be conducted by selected Field Advisory Group members and/or a VACO representative. Outcomes to be monitored include the impact of case management services on:

(a) the extent to which clients are receiving services.

(b) effectiveness of the services provided in terms of meeting client's needs.

(c) the interaction between agencies involved in local service networks.

(d) evaluation of the entire case management system in objective terms, especially in meeting its goals of employment and independence.

c. Annual Report (RCS 10-0109)

(1) Preparing Offices: The Case Manager Annual Report (VAF 10-0025a) will be prepared and submitted by designated case managers in either Rehabilitation Medicine Service, Psychology Service, or Social Work Service at all VA medical centers.

(2) Frequency and Report Period: This will be an annual report covering case management activities from October 1 through September 30. Reports should be received in VACO by the 15th workday of the month (October) following the end of the reporting period.

(3) General Instructions for Completing Report:

(a) Line "7" of report asks for the percentage of work during any week during the year which is devoted specifically to case management duties. Even if you are a designated full-time case manager, there may be instances where you are assigned other duties -- not related to case management (line "8"). Indicate any separation of responsibilities and describe those duties not covered by "case management".

(b) Line "9" asks for number of patients seen. Patients who may return later during the year for re-evaluation or assignments may be counted for as many times as they enter the program during that fiscal year. The Inpatient/Outpatient and Service-Connected/Non-Service Connected totals should add up to the total number of patients you have seen for that year. The number of "Patients Screened, No Other Services Provided" should be a part of the "Total Number of Patients Seen".

(c) Line "10" (Disposition): Each of these categories are requesting numbers of patients (including re-referrals or re-admissions).

NOTE: DVB/VR&C means "Department of Veterans Benefits/Vocational Rehabilitation and Counseling.

(4) Preparation of Report: An original VAF 10-0025a and one copy should be sent to Central Office, Reports Processing Section (722A). (VAF 10-0025b should no longer be used).

NOTE: Some case managers may find it necessary to provide data for two separate reports. For example, a counseling psychologist designated as case manager will continue to provide data to the quarterly Psychology AMIS, as well as to the Case Management Annual Report.

5. REFERENCES:

a. Program Guide, Mental Health and Behavioral Sciences, Counseling Psychology, G-17, M-2, Part X, 1981.

b. Program Guide, Work Restoration, G-11, M-2, Part VIII, 1983.

c. Rehabilitation Services - JCAH, Consolidated Standards Manual, 1985, Chapter 30.

6. RESCISSIONS: This DM&S Circular will be rescinded on August 5, 1988.

7. FOLLOW-UP RESPONSIBILITY: Director, Rehabilitation Medicine Service (117)

John A. Gronvall, M.D.
JOHN A. GRONVALL, M.D.
Chief Medical Director

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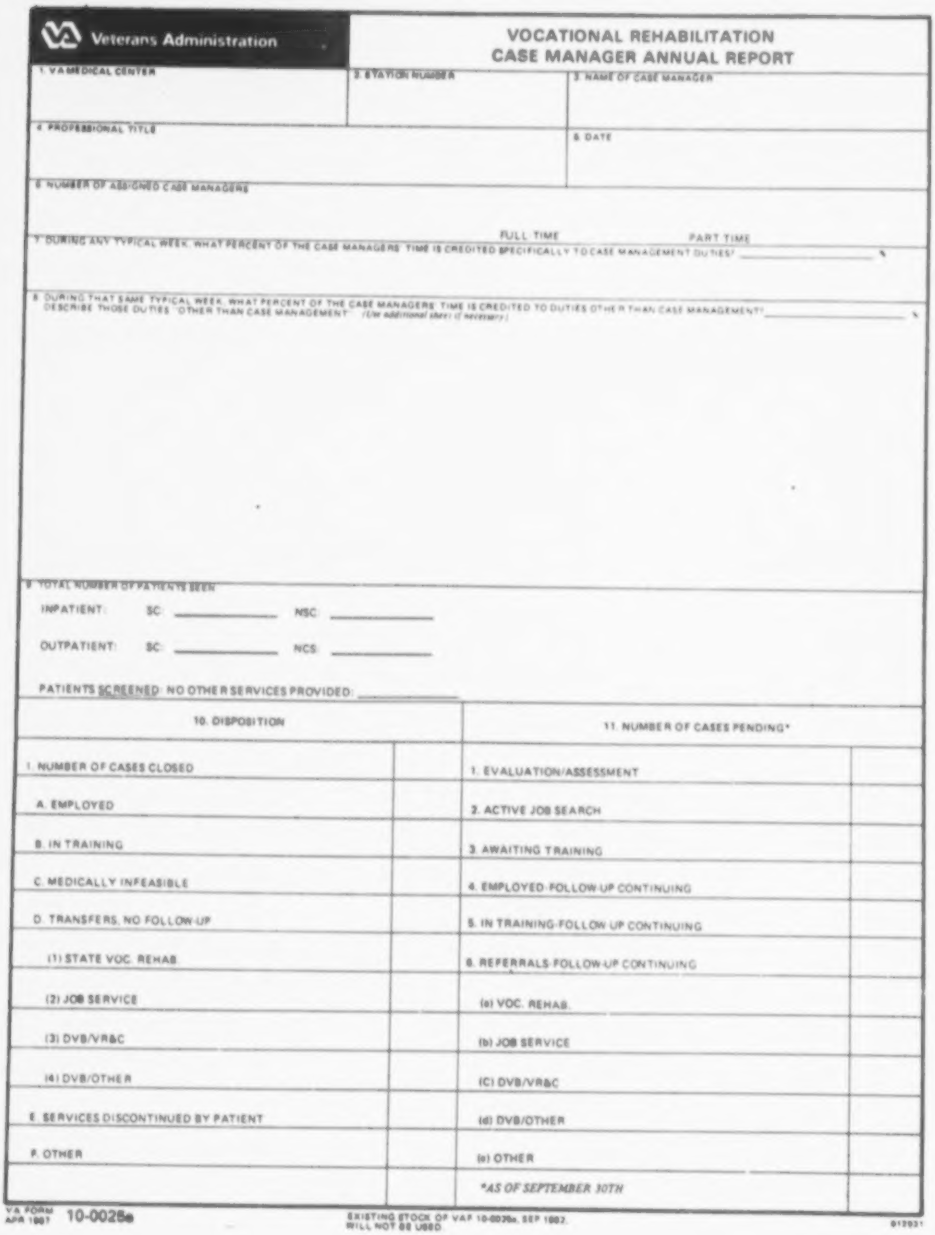


Veterans Administration

VOCATIONAL REHABILITATION CASE MANAGER ANNUAL REPORT

1. VA MEDICAL CENTER
2. STATION NUMBER
3. NAME OF CASE MANAGER
4. PROFESSIONAL TITLE
5. DATE
6. NUMBER OF ASSIGNED CASE MANAGERS

FULL TIME PART TIME

7. DURING ANY TYPICAL WEEK, WHAT PERCENT OF THE CASE MANAGERS' TIME IS CREDITED SPECIFICALLY TO CASE MANAGEMENT DUTIES? ____________ %

8. DURING THAT SAME TYPICAL WEEK, WHAT PERCENT OF THE CASE MANAGERS' TIME IS CREDITED TO DUTIES OTHER THAN CASE MANAGEMENT? ____________ %
DESCRIBE THOSE DUTIES "OTHER THAN CASE MANAGEMENT" *(Use additional sheet if necessary.)*

9. TOTAL NUMBER OF PATIENTS SEEN

INPATIENT: SC: ____________ NSC: ____________

OUTPATIENT: SC: ____________ NCS: ____________

PATIENTS SCREENED: NO OTHER SERVICES PROVIDED: ____________

10. DISPOSITION		11. NUMBER OF CASES PENDING*	
1. NUMBER OF CASES CLOSED		1. EVALUATION/ASSESSMENT	
A. EMPLOYED		2. ACTIVE JOB SEARCH	
B. IN TRAINING		3. AWAITING TRAINING	
C. MEDICALLY INFEASIBLE		4. EMPLOYED-FOLLOW-UP CONTINUING	
D. TRANSFERS, NO FOLLOW-UP		5. IN TRAINING-FOLLOW-UP CONTINUING	
(1) STATE VOC. REHAB.		6. REFERRALS-FOLLOW-UP CONTINUING	
(2) JOB SERVICE		(a) VOC. REHAB.	
(3) DVB/VR&C		(b) JOB SERVICE	
(4) DVB/OTHER		(C) DVB/VR&C	
E. SERVICES DISCONTINUED BY PATIENT		(d) DVB/OTHER	
F. OTHER		(e) OTHER	
		**AS OF SEPTEMBER 30TH*	

VA FORM APR 1987 10-0026a

EXISTING STOCK OF VAF 10-0026a, SEP 1982, WILL NOT BE USED.

012031

The results of Dr. Magraw's survey of September 1987 on current and potential psychiatric vacancies, was included in a "white paper" entitled "Analysis of Psychiatric Physician Vacancies" (April 12, 1988). (Attachment A) This document, written to describe the existing shortage of psychiatrists in the VA and concerns for future potential losses was routed through the Office of the ADCMD (Dr. Winship) to the Chief Medical Director.

"Analysis of Psychiatric Physician Vacancies" includes data from a March 1986 survey by Mental Health and Behavioral Sciences Service that indicated 141 psychiatric physician vacancies at that time. Twenty-one VA facilities surveyed reported at least one position vacant continuously for at least one year. In addition, the paper documents 146 psychiatric physician vacancies as of December 31, 1987. This represents a 7.2% vacancy rate for Psychiatry: higher than that for either Medicine and Surgery. The source of this data was a Report to Congress required by P.L. 96-330, the Veterans Administration Health Care Amendments of 1980. (More recent data, acquired from the VA's COIN DMS 124, RCS 17-5 report for the 2nd quarter of FY 1988, reveals 164 psychiatrist vacancies and a 15-month average duration for the 23 vacant Chief of Psychiatry positions.) A review of the RCS 10-0037 (Quarter Name List of DM&S Personnel in Pay Status) indicated that 379 VA psychiatrists will become eligible for retirement by 1990; 161 of them currently employed at the 42 predominantly psychiatric VA Medical Centers.

The "Analysis" paper includes the recommendations submitted by Chiefs of Psychiatry subsequent to Dr. Magraw's report. These four recommendations are:

O Identification of Psychiatry as a scarce specialty

O Incentive pay on the basis of geographic isolation (which has been implemented by several stations).

O Expansion of psychiatric residences to enhance the pool of psychiatrists available to the VA (psychiatry is not one of those specialties experiencing a so-called physician "glut").

O Enhancement of working conditions in terms of workload and research opportunities to make VA employment more competitive with other academic settings.

Included in the "Analysis" paper was a plan for a further field survey of psychiatric vacancies. The growing concern about shortages of psychiatrists expressed by several DM&S Regions resulted in the release of this latest survey to all VA medical centers in June 1988 (Attachment B). This survey questionnaire elicits information not only about number and duration of psychiatric vacancies, but also about the training level of incumbent psychiatric staff. Also, input from VAMCs is solicited on causes of any perceived shortage of psychiatrists as well as suggestions about correcting this shortage.

Results of this latest survey should be in VA Central Office later this summer. The data will be collated and summarized for presentation to the CMD. Based on the results of the June-July 1988 survey, Dr. Magraw's survey or some combination of the two appropriate corrective actions will be recommended.

Attachment A: "Analysis of Psychiatric Physician Vacancies" (4/12/88)
Attachment B: Psychiatric Recruitment and Retention Survey (6/88)

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY

ANALYSIS OF PSYCHIATRIC PHYSICIAN VACANCIES
A WHITE PAPER DESIGNED TO ALERT VA CENTRAL OFFICE OFFICIALS
OF THE EXISTING SHORTAGE OF VA PSYCHIATRISTS AND CONCERNS FOR THE FUTURE

A significant shortage of psychiatrists has existed within the VA medical care system since 1986 and analysis of available data and trends indicates this deficit will continue unabated unless the VA implements procedures to attract and retain physicians in this medical specialty. This shortage is occurring at a time of escalating inpatient and outpatient psychiatric workloads that reflect the increasing needs of veterans eligible for VA care, and it threatens our ability to provide optimal mental health services for those whom it is our duty to serve.

a. As shown in Table 1, the number of psychiatric vacancies has steadily increased, from 68 (December 31, 1985) to 110 (December 31, 1986) to 146 (December 31, 1987). This 1987 figure represents 7.2% of the total 2,028 psychiatrist positions in the VA. The 7.2% vacancy rate is higher than that of either of the other two major bed services disciplines (Medicine and Surgery). It is virtually double the Medicine vacancy rate (3.8%).

b. The 7.2% vacancy rate for Psychiatry is greater than the vacancy rate for any of the five categories already designated as scarce medical specialities (Anesthesia, Orthopedics, Pathology, Radiology, and Physical Medicine). The highest of these, Radiology, was only 6.6% as of December 31, 1987.

c. The impairment in recruiting psychiatrists is reflected in Table 2, which shows that while 263 Psychiatric vacancies were filled in 1986 (an increase of 68 over the previous year), only 265 vacancies were filled in 1987. In a year that ended with thirty-six more psychiatric vacancies, only two more psychiatrists were hired. In contrast, Medicine filled 636 vacancies in 1986 (an increase of 75) and 726 vacancies in 1987 (an increase of 90 over the previous year).

d. Table 3 indicates that the average duration of vacancies for psychiatry (5.5 months in 1987) is the largest for any of the three major services, and it is increasing.

e. The above data are taken from the most recent Report to Congress required by P.L. 96-330, the Veterans Administration Health Care Amendments of 1980. This report is prepared by Management Support Office.

Two previous surveys have indicated that this problem in recruitment and retention of psychiatrists exists. In March 1986, Mental Health and Behavioral Sciences Service conducted a telephone survey of all Psychiatry Services (Attachment 1) which revealed 141 psychiatric physician positions to be vacant. The PAID file at that time reported only 79 psychiatrist vacancies. Twenty-one VA facilities surveyed reported at least one position vacant continuously for a year.

In the Fourth Quarter of FY 1987, Dr. Richard Magraw, President of the National Association of VA Chiefs of Psychiatry, carried out a telephone survey of 50 VA Psychiatry Services and identified 77 vacancies. He projected from this data 231 possible vacancies system-wide for psychiatry, with the possibility of 400 vacancies (including possible retirements) in 1988. The Fourth Quarter, FY 1987, Psychiatry Physician vacancies reported on the COIN DM&S 124/RCS 17-5 noted 'only' 120 vacancies for this period.

a. Dr. Magraw reported on his survey to VA Central Office in September 1987 and subsequent to this a subcommittee report on Recruitment and Retention of VA Psychiatrists was submitted (Attachment 2).

These surveys, which demonstrate growing shortages of psychiatric physicians system-wide, along with concerns of under-reporting in the official count of vacancies, prompted the writing of this paper. Furthermore, the Mental Health and Behavioral Sciences Service intends to carry out an additional field survey which would document not only current psychiatric vacancies and their duration, but also gather information on impediments to recruitment and retention and possible solutions to the dilemma as perceived in the field.

a. As a first phase of this survey, a review of the RCS 10-0037 (Quarter Name List of DM&S Personnel in Pay Status) was carried out to identify the number of psychiatrists who will become eligible for retirement between 1988 and 1990. This study revealed that 379 psychiatrists will become eligible for retirement by 1990: 161 of these 379 physicians are employed at the 42 predominantly psychiatric VA Medical Centers.

b. These data are displayed as number of psychiatrists eligible to retire by Region (Figure 1), as percentage of retirement eligible psychiatrists by Region (Figure 2), and as psychiatrists eligible to retire by year of eligibility (Figure 3).

At the recent conference on Resource Allocation Methodology for Chiefs of Psychiatry, each of the Seven Regional working groups identified recruitment and retention problems as a major issue. This paper has been written to identify recruitment and retention of psychiatrists as a significant problem for the VA. Several suggestions for resolution of this problem have been made in the 1987 Subcommittee Report on Recruitment and Retention (Attachment 2) these include:

a. Identification of Psychiatry as a scarce specialty.
b. Additional incentive pay on the basis of geographic isolation.
c. Expansion of psychiatric residencies to enhance the pool of potential psychiatrists available to the VA.
d. Enhancement of working conditions in terms of workload and research opportunities to make VA employment more competitive with other academic settings.

It is hoped that the survey being planned will provide additional documentation on the recruitment and retention problems for VA psychiatry and enhance the development of solutions.

LAURENT LEHMANN, M.D.
Associate Director for Psychiatry
April 12, 1988 (116A1)

TABLE 1

Specialty Assignment	Number of Vacancies at End of Year			Total on Duty Plus Vacancies	Percentage Vacancies
	1985	1986	1987	1987	1987
Psychiatry	68	110	146	2,028	7.2%
Medicine	117	155	188	4,936	3.8%
Surgery	83	132	125	2,876	4.3%
Anesthesiology	17	23	23	354	6.5%
Orthopedic Surgery	10	18	19	353	5.4%
Pathology	12	12	19	584	3.3%
Radiology	18	92	50	761	6.6%
Physical Medicine	9	9	18	354	5.1%

TABLE 2

NUMBER OF VACANCIES FILLED DURING YEAR

Specialty	1985	1986	1987
Psychiatry	195	263	265
Medicine	561	636	726

TABLE 3

AVERAGE NUMBER OF MONTHS PER VACANCY

Specialty	1985	1986	1987
Psychiatry	4.8	5.2	5.5
Medicine	4.8	4.3	4.5
Surgery	5.5	5.3	5.2

ANALYSIS OF PSYCHIATRIC PHYSICIAN VACANCIES

The attached tables displaying the number of psychiatric physician vacancies provides a broad spectrum of interesting information. These tables were derived from the PAID file, but they may have underestimated the number of psychiatric vacancies. Mental Health and Behavioral Sciences Service conducted a telephone survey in response to a congressional inquiry which identifies a higher number of vacant positons.

The reasons for the differences between the Paid report and the responses of individual psychiatry sertvice chiefs are somewhat unclear, but include a variety of possibilities:

a. physicians who have accumulated annual leave may use it up or be paid a lump sum. Those who leave the V.A. often use their leave, thereby remaining in a paid status for weeks or months beyond their actual departure date.

b. A few physicians may be on sick leave prior to retirement and are counted as on duty.

c. It is not uncommon for a physician vacancy to occur which is partly filled by a part-time person while recruitment for a permanent individual is in process. These part-time replacments do not provide a comparable level of clincial activity to full time staff, but the vacancy is not reported.

There may also be other reasons for the differences, which are difficult to identify.

In the MH&BSS survey, 141 positions and 135 FTEE were vacant in March of 1986. In contrast, according to the PAID file, there were 79 vacancies including 67 full time positions.(PAID identified 48% of the functional vacancies identified by this service.)

In some locations, retention of staff and recruiting difficulties create a problem of persisting vacancies. In this situation, physicians leave often, and despite replacement in three to six months, the facility is always short of physicians. No individual position is vacant for a long period, but the facility has vacancies for years at a time, adversely effecting the quality of patient care, and gradually damaging the ability of the medical center to obtain competent physicians. Neither the PAID file data nor the MH&BSS survey adequately describe this situation.

Twenty-one V.A. facilities reported at least one position vacant continuously for a year.

Results of Phone Survey of 146 VA Medical Centers to Respond to Congressional Questions
(Survey conducted March 1986)

I. Psychiatry Residency:

- 28 facilities reported 39 physicians who have not completed full-time psychiatric residencies.
  38 FT
  1 PT

II. Clinical Privileges

- 29 of the physicians have limited clinical privileges;
- 10 have no restrictions, several stating that clinical privileges are based on individual training.

III. Psychiatric Physician FTEE Vacancies:

Total Psychiatrist FTEE Nationwide: 1,616.2
(135.12 vacancies (8.4%))

	Number VAMC's Reporting	Number FTEE	Total FTEE	Extended FTEE Vacancies	
	1	0.175	0.175		
	1	0.75	0.75		
	4	0.5	2.0		
	4	0.6	2.4		
	38	1.0	38.0	(5) 1 yr +	13%
	1	1.2	1.2		
	1	1.3	1.3		
	2	1.5	3.0	(2) 1 to 2 yrs	67%
	1	1.9	1.9	(.7) 1 yr +	37%
	13	2.0	26.0	(5) 1 to 2 yrs	19%
	1	2.4	2.4	(2.4) 2 yrs	100%
	8	3.0	24.0	(6) 1 yr +	25%
	5	4.0	20.0	(12) 1 yr +	60%
	1	5.0	5.0	(1) 1 yr	20%
	1	7.0	7.0	(5) 1 yr	71%
TOTAL	82		135.12	39.1/29%	

IV. Length of Vacancy by Positions:

(141 total positions vacant)

1-3 weeks	8	6%
4-6 weeks	6	4%
1-3 months	46	33%
4-6 months	25	18%
7-9 months	16	11%
12-17 months	24	17%
15-17 months	9	6%
18-23 months	0	0
24-26 months	7	5%
	141	100%

Ranking: Extended FTEE Vacancies:

1	Pittsburgh, PA (HD)	(7) total (5) for 1 yr.
2	Chillicothe, OH	(5) total (1) for 1 yr.
3	Montrose, NY	(4) for 1-1/4 yrs.
4	Canandaigua, NY	(4) for 1.4 yrs.
5	Murfreesboro,TN	(4) total (3) for 1 yr.
6	Little Rock, AR	(4) total (1) for 1 yr.
7	Lexington, KY	(3) for 1 yr.
8	Seattle, WA	(3) for 1 yr.
9	Ann Arbor, MI	(2.4) for 2 yrs.
10	Buffalo, NY	(2) for 2 yrs.
11	Fargo, SD	(2) total (1) for 1 yr.
12	Shreveport, LA	(2) total (1) for 1 yr.
13	Brooklyn, NY	(2) total (1) for 1 yr.
14	Richmond, VA	(1.9) total (.7) for 1 yr.
15	Syracuse, NY	(1.5) for 2 yrs.
16	West Haven, CT	(1.5) total (1) for 1 yr.
17	Birmingham, AL	(1) for 1 yr.
18	Columbia, SC	(1) for 1 yr.
19	Houston, TX	(1) for 1 yr.
20	Mt. Home, TN	(1) for 1 yr.
21	Sioux falls, SD	(1) for 1 yr.

PAID FILE DATA

FULL-TIME

	# on duty at end of year			# vacancies at end of year			# vacancies filled/year			# months vacant (avg.)		
	83	84	85	82	83	84	82	84	84	82	83	85
Surgery:												
	793	782	808	55	89	53	20	17	22	9.2	8.9	9.3
	% vacant (vac./on duty)						% filled (filled/on duty)					
	7%	11%	7%				3%	2%	3%			
Medicine:												
	2,640	2,646	2,764	127	150	91	80	51	42	6.0	6.1	6.0
	% vacant (vac./on duty)						% filled (filled/on duty)					
	5%	6%	3.2%				3%	2%	2%			
Psychiatry:												
	1,274	2,646	2,764	61	70	67	52	26	15	5.5	6.1	4.4
	% vacant (vac./on duty)						% filled (filled/on duty)					
	5%	5.4%	5.1%				4%	2%	1%			
Radiology:												
	462	457	476	21	24	17	16	5	12	16.1	8.9	6.4
	% vacant (vac./on duty)						% filled (filled/on duty)					
	5%	5.2%	4%				3%	1%	2.6%			
Pathology:												
	441	444	449	23	17	7	4	3	4	13.7	12.8	5.3
	% vacant (vac./on duty)						% filled (filled/on duty)					
	5%	4%	2%				.9%	.6%	.8%			

PAID FILE DATA

ALL VA PHYSICIANS:

	# on duty at end of year			# vacancies at end of year			# vacancies filled/year			# months vacant (avg.)		
	83	84	85	83	84	85	83	84	84	83	84	85
Surgery:												
	2,406	2,484	2,642	114	163	95	79	71	68	6.7	7.0	7.6
% vacant (vac./on duty)							% filled (filled/on duty)					
	5%	7%	4%				3.2%	3%	3%			
Medicine:												
	4,142	4,271	4,516	178	209	132	136	110	103	6.2	5.9	6.3
% vacant (vac./on duty)							% filled (filled/on duty)					
	4.2%	5%	3%				3.2%	3%	2.2%			
Psychiatry:												
	1,946	1,926	1,940	82	92	79	74	37	41	5.3	6.2	4.0
% vacant (vac./on duty)							% filled (filled/on duty)					
	4.2%	5%	4%				4%	2%	2.1%			
Radiology:												
	665	668	702	30	33	23	29	8	15	12.1	9.0	5.9
% vacant (vac./on duty)							% filled (filled/on duty)					
	5%	5%	3.2%				4.3%	1.1%	2.1%			
Pathology:												
	557	572	574	28	30	15	6	8	6	12.1	11.3	8.4
% vacant (vac./on duty)							% filled (filled/on duty)					
	5%	5%	3%				1.0%	1.3%	1.0%			

Report of the Subcommittee:

Recruitment and Retention of Psychiatrists in VA Medical Centers

Meeting in VACO September 21, 1987

A recent survey of Psychiatry Services in the VA system indicates that in FY'88 approximately 550 to 600 additional, fully trained and qualified Psychiatrists would need to be recruited to completely fill out the approximately 1550 FTEE positions for staff psychiatrists in the entire VA. (Approximately 400 of these are now vacancies or will become vacancies in 1988. The balance includes staff psychiatrist positions now filled by persons who have not had psychiatric training.)

In addition there are indications that because of the rates of remuneration now available to qualified psychiatrists in public mental hospitals, there will be further erosion in the retention rate of psychiatrists in the VA. (In a substantial number of state mental hospital systems, psychiatrists earn $20 to 40,000 more per year than comparable pay in the VA system.)

Hence on the basis of existing and forseeable needs for psychiatric staff in the Veterans Administration system, and in the light of national demand for psychiatrists, we make the following recommendations:

Recommendation 1 - The Department of Medicine and Surgery declare Psychiatry to be a "scarce specialty" with corresponding potential increases in incentive pay (analagous to what anesthesiologists, pathologists, etc., are now receiving). We further recommend that, as is appropriate to the recruitment and retention situation in individual Medical Centers, the respective Medical Center Directors increase the incentive pay for psychiatrists on their staff pursuant to existing DM&S authority.

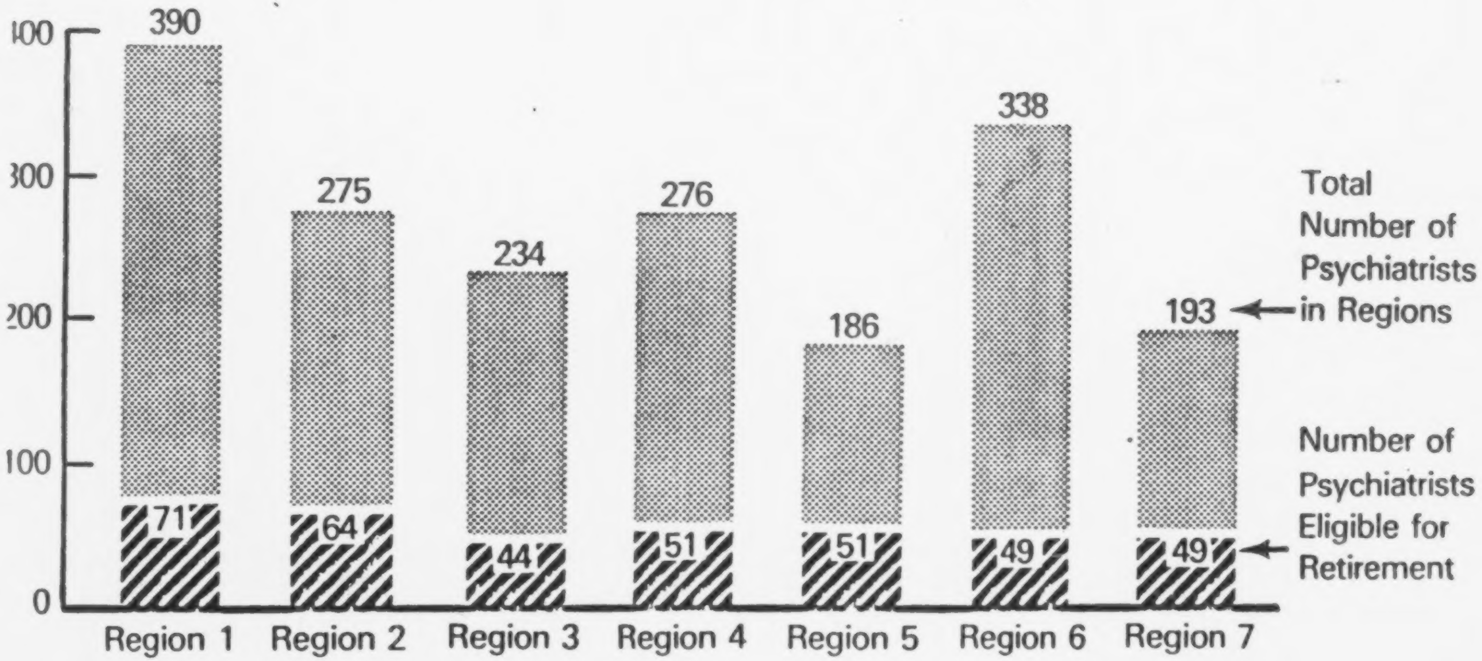
Recommendation 2 - Where appropriate, additional incentive pay should be encouraged and authorized on the basis of geography. This would include those non-affiliated, non-metropolitan VA Medical Centers having extraordinary difficulties with retention and with recruitment of psychiatrists. Such authorization should be for sufficiently lengthy periods to effectively enhance recruitment and encourage retention of psychiatric staff.

Recommendation 3 - Efforts should be made to expand psychiatric residency programs in the VA in such a way that the pool of potential new psychiatrists available to the VA Medical Centers is increased.

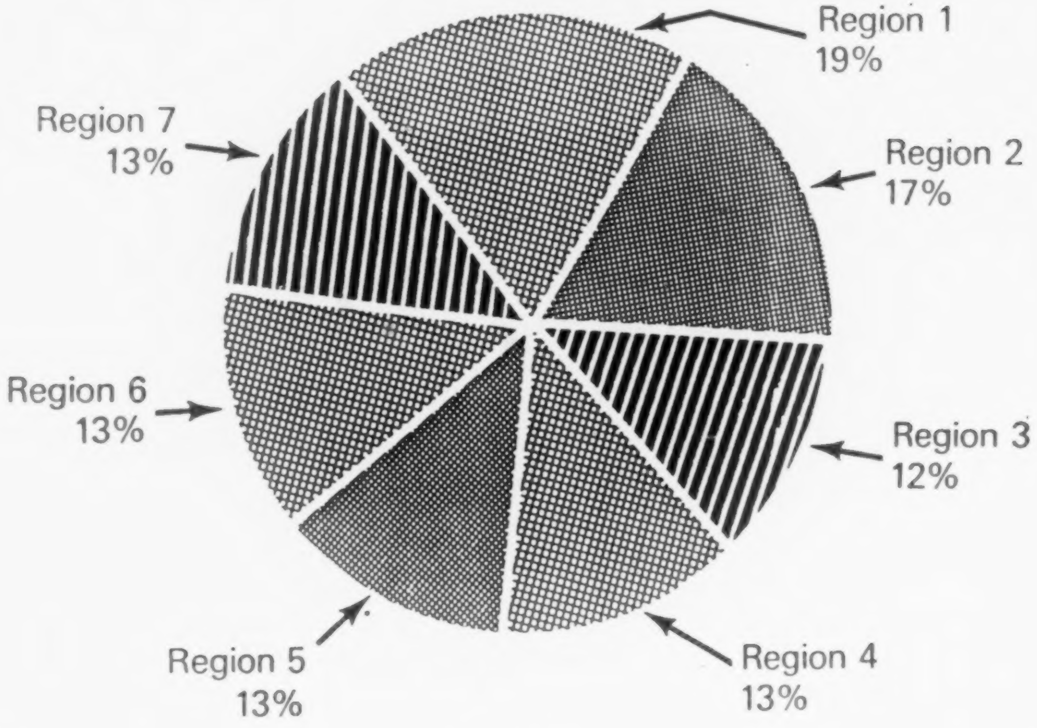
Recommendation 4 - Wherever feasible, clinical workloads for psychiatrists should be maintained at levels consistent with the academic achievement of the staff psychiatrists. Research facilities, funding and time should be increased in order to provide opportunity for the academic development of psychiatrists and for the maintenance of an appropriate academic milieu for resident education.

Chairman of the Subcommittee: John Benson, M.D.
Chief, Psychiatry - VAMC Augusta GA

Table Representing the Number of Psychiatrists Eligible for Retirement 1988 - 1990 by Region

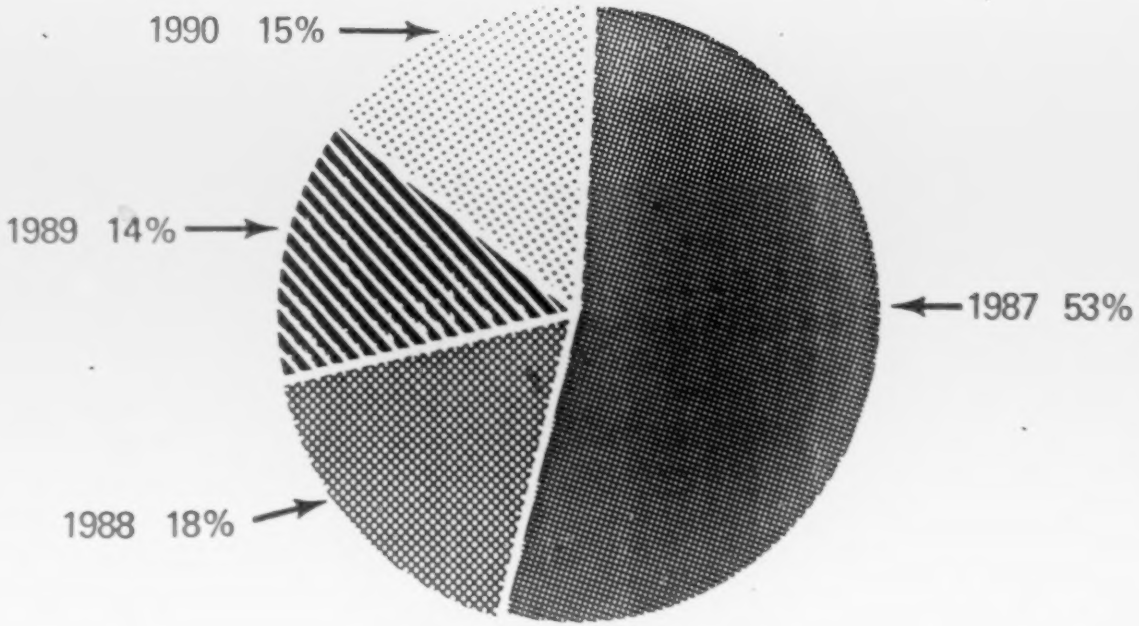


Percentage of Retirement Eligible Psychiatrists by Region (1988 - 1990)



N = 379

Psychiatrists Eligible to Retire by Year of Eligibility
1987 - 1990



Name of VAMC ______________
Date ______________

Questions for Psychiatry Recruitment and Retention Survey

1. Current (2nd Quarter, FY 88) Psychiatry physician vacancies?

	Full Time		Part Time	
	Vacancy (FTE)	Duration (months)	Vac. (FTE)	Dura. (months)
Chief				
Staff				

2. a) Has your estimate of duration of vacancy (above items 1 & 2) been effected by shifts of staff into a previously vacant position, thereby shifting the vacancy to another position? If yes, describe briefly.

   b) Have any vacancies been "dropped" from recruitment or vacancy status by filling from another source (e.g. "part timer" from the community)? ______________

3. Training status of current psychiatric staff.

   a) # with American Board of Psychiatry & Neurology (ABPN) Psychiatry Boards? ______________

   b) # who have completed an ABPN approved Psychiatric Residency program (are ABPN board eligible) ______________

   c) # who are not Board eligible? ______________

      1. Of these, how many have any formal Psychiatric training (at least one year)?

      2. How many have no formal Psychiatric training (less than one year)? ______________

      (NOTE: 3a + 3b + 3c = Psychiatric MD's on staff, excluding residents).

Page 2.

4. Which of the following factors do you consider to be most relevant with regard to the psychiatrist vacancies/recruitment and retention difficulties you are experiencing?

a) Shortage of Psychiatrists in your community? ___________
b) Psychiatrists moving to another major employer? ________

1. If so, is it: medical school? ________
state? ________
private practice? ______

2. Identify primary reason for attractiveness of competitor vs. the VA?
a) Salary differential? State approximate amount of difference between VA and competitor ___________
b) Workload differential? State approximate amount of difference between VA and competitor ___________
c) Fringe benefits? If so, please describe __________

c) Other? _______

5. What suggestions do you have to improve recruitment and retention of Psychiatrists in the VA?

STATEMENT OF
DR. DENNIS R. WYANT
DIRECTOR, VOCATIONAL REHABILITATION
AND EDUCATION SERVICE
VETERANS ADMINISTRATION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JUNE 16, 1988

Mr. Chairman and members of the Committee:

I am pleased to be here today to brief you on the state of the chapter 31 vocational rehabilitation program and counseling programs which the VA administers.

As you know, Mr. Chairman, Public Law 96-466, instituted a number of significant changes in the veterans' vocational rehabilitation program effective April 1, 1981. Not only did this law serve to broaden the scope of this program and create new services, but even more importantly, the comprehensive study leading to passage of Public Law 96-466 cited the need for a shift in the focus of the rehabilitation program. The recommended shift was from simple restoration of the veteran's employability, through training, to the provision of all services and assistance necessary for the veteran to achieve actual employment and independent functioning in daily living. This change in the focus of the program required more comprehensive counseling, evaluation and diagnostic services, individually written plans of rehabilitation services, and employment services to assure the veteran sustained suitable employment.

Mr. Chairman, I would like to summarize where we are in the chapter 31 program today and review with you recent accomplishments and planned initiatives which have particular relevance to one of the VA's highest priorities--rehabilitating disabled veterans.

Vocational Rehabilitation and Counseling staff are currently located at Central Office, 58 regional offices, and 44 outbased facilities. The field divisions currently employ a staff of 577 which includes 274 counseling psychologists, 150 vocational rehabilitation specialists, and a support staff of 153. Additionally, six regional offices use contract counseling centers to provide educational and vocational counseling services. These centers are used to provide counseling services only to non-disabled veterans and dependents.

Disabled veterans requesting assistance under chapter 31 and who meet basic eligibility requirements are provided a comprehensive initial evaluation. The comprehensive initial evaluation ensures that they receive the opportunity to fully explore the problems they are encountering in achieving independence in daily living and in preparing for, obtaining, and maintaining suitable employment. During Fiscal Year 1987, 39,496 disabled veterans were provided chapter 31 initial evaluations. In addition, similar evaluations were provided 6,655 veterans during the first 3 years of the chapter 15 pilot program. The number of disabled veterans completing chapter 31 initial evaluations has remained relatively stable over the past 4 years, perhaps reflecting the buildup of the peacetime military forces.

During Fiscal Year 1988, 68 percent of veterans completing an initial evaluation were found eligible and entitled to rehabilitation services and assistance under chapter 31. The percent of chapter 31 veterans completing an initial evaluation and found eligible and entitled to rehabilitation services has averaged 69 percent over the past 5 years.

At present, 24,175 veterans are actively participating in a program of rehabilitation services. VR&C staff is also working with an additional 7,472 veterans who have interrupted their programs because of personal, academic, or health problems. Most are expected to return to active participation in a vocational rehabilitation program with the assistance provided by VR&C staff in resolving the problems which caused interruption. One-third of the participants have serious employment handicaps, 92 percent are male, and 75 percent are between 26 and 45 years of age. Eighty percent had either a high school diploma or GED when entering the rehabilitation process. The number of disabled veterans provided rehabilitation services has been relatively constant over the past 4 years, averaging more than 24,000 per year. Of the disabled veterans currently participating in a program of rehabilitation services, 3,562 have received services to the point that they are considered "job ready" and are receiving employment services.

In Fiscal Year 1987, we reviewed 632 cases in which veterans who had received chapter 31 services were declared to be rehabilitated. Under our strict criteria, if a veteran completes his or her program of services, and employment is obtained in the occupation for which services were provided, we consider the veteran rehabilitated if he or she maintains that suitable employment for at least 90 days. The results of our review showed that field staff were not consistently applying these precise criteria in declaring veterans rehabilitated. We provided additional guidance to field staff on the interpretation of the regulations governing rehabilitation declarations and this resulted in a drop in the number of cases determined to be rehabilitated to about 2,400. In prior years we had averaged about 3,600. Our further analysis of the cases reviewed found that there are a significant number in which veterans derive substantial benefit from participation in the vocational rehabilitation program, but these benefits are not measured by our current criteria for determining program success. One example is the situation in which a veteran completes his or her program, and defers employment because he or she elects to pursue additional higher education, beyond that which needs to be furnished under chapter 31 for the veteran to qualify for suitable employment.

Even though this person is job-ready, since he or she is not suitably employed, no measure of rehabilitation success may be recorded. We are exploring ways of recognizing all benefits which veterans derive from program participation, but which are not currently recognized by our criteria for rehabilitation.

We have expanded our use of contracting for certain extended evaluation services with non-profit organizations and are now exploring ways of using contracted services to provide employment assistance and other services where VA services are not available.

Public Law 96-466 authorized the VA to provide independent living services to participants in vocational rehabilitation programs and also established a program of independent living services for veterans who are seriously disabled, and for whom achievement of a vocational goal is currently infeasible. A 4-year pilot program was established. Following an evaluation of the results of the pilot program, Congress extended this program through Fiscal Year 1989, under the provisions of Public Law 99-576, the omnibus Veterans' Benefits Improvement and Health-Care Authorization Act of 1986. Many disabled veterans initially receive independent living services as part of the medical rehabilitation process. However, VR&C staff has approved for participation in the chapter 31 independent living program 21 very seriously disabled veterans since the program was extended. In addition, in Fiscal Year 1987, 19 seriously disabled veterans achieved independence, or a greater degree of independence, in daily living through this program.

Mr. Chairman, I would now like to provide you with an overview of improvements and recent program accomplishments which are enhancing the quality and timeliness of services to veterans in the chapter 31 program.

As you know, Public Law 96-466 required the appointment of an advisory committee to be known as the Veterans' Advisory Committee on Rehabilitation. The Committee assesses the rehabilitation needs of veterans, reviews the programs and activities of the Veterans Administration designed to meet those needs, and offers recommendations to the Administrator concerning the administration of the veterans rehabilitation program. The Committee held its first meeting March 16, 1982, and has been active in reviewing the implementation and operation of the vocational rehabilitation program. One significant Committee initiative is the current evaluation of the chapter 31 program being conducted by the VA's Office of Program Analysis and Evaluation. The evaluation was begun on the advice and recommendation of the Committee, and is designed to analyze the effectiveness of the vocational rehabilitation program. The Department of Veterans Benefits and Vocational Rehabilitation and Counseling program management endorsed this recommendation and has supported its implementation.

The Advisory Committee has also encouraged a greater degree of coordination of rehabilitation services with the Department of

Medicine and Surgery through the case management system. A significant result of this emphasis is the improved coordination of rehabilitation services to veterans with closed head injuries. The medical evaluations and assessments provided by DM&S have enhanced the quality of chapter 31 evaluation and planning of services for this population of seriously disabled veterans.

The provision of effective employment services is essential to the mission of the VA's vocational rehabilitation program. We have completed a number of initiatives to strengthen the employment services phase of the rehabilitation process. First, we recently conducted six regional training workshops in which training was provided specifically to improve this service. Each program manager, counseling psychologist, and vocational rehabilitation specialist participated. Ongoing training of this type is critical to the effective operation of the disabled veterans vocational rehabilitation program. Secondly, we have initiated action to revise and update the VA-DOL employment services agreement. Associated state agreements will soon be updated, improving interagency coordination and cooperation.

We have initiated an aggressive campaign to increase employment opportunities for chapter 31 disabled veterans. We are working with private sector small employers such as the Diamond Precision Company in San Diego, larger ones such as the Teledyne Ryan Corporation, also in San Diego, and still larger international employers such as Lockheed Corporation. Additionally, we are working with small and large public sector employers such as the regionalized Tennessee Valley Authority and the U.S. Postal Service. To date, the Internal Revenue Service, Office of Personal Management, Small Business Administration, the National Aeronautics and Space Administration, the Federal Bureau of Investigation, the General Services Administration, and the Department of Health and Human Services have shown interest in working with us in hiring disabled veterans completing rehabilitation programs under chapter 31. We recently completed a mailing to 25,000 private sector employers, providing them with information about the chapter 31 program and encouraging them to contact VR&C staff in their geographical area when seeking qualified job applicants.

Finally in Fiscal Year 1988, we created an Employment Task Force consisting of VR&C staff to study the obstacles to employment of disabled veterans in rehabilitation programs. The task force identified a number of constraints to effective delivery of employment services, including the broad geographic distribution of disabled veterans and the need for staff development in job placement skills. As noted above, we have already partially addressed the last issue through staff training; however, further training is needed. The Task Force also identified on-job training as an effective means of developing suitable employment. In particular, the use of training and work experience at no or nominal pay in Federal agencies has greatly enhanced the vocational rehabilitation program.

Mr. Chairman, as the Congress recognized in enacting Public Law 96-466, the success of the chapter 31 program is dependent on the effective employment of disabled veterans. Thus, we continue to look for ways to further improve this critical part of the program. One such improvement which we have proposed would extend the authority to establish nonpay programs of training and work experience to state and local agencies. This proposal is contained in the Agency's bill, S. 2307, which you introduced on our behalf, and we would urge its prompt enactment.

We are working on a number of initiatives to further enhance the quality of services to veterans. We have developed a new quality review system which will be field-tested this year and should be fully implemented next year. The current quality control system adequately identifies errors, but is not as effective in identifying ways of improving the quality of rehabilitation services. The revised system is designed to reinforce quality aspects of rehabilitation work while noting areas of weakness and corrective actions needed.

The current chapter 31 payment system in Target is extremely limited in its capabilities, requiring manual processing which results in delayed services and creation of debt through overpayments. In 1983, the first phase of the chapter 31 modernization initiative was incorporated in the Target system. Phase II, the chapter 31 payment system redesign, is currently planned for installation in late 1989.

The installation of the chapter 31 Phase II payment system will remedy many of the payment and internal control problems experienced with the current system. Subsistence award processing and other related functions will be comparable and compatible with other automated veterans' benefit delivery systems and more accurate and timely service to the veteran will be provided.

Some additional program accomplishments to enhance service delivery include diminishing the administrative burden on our field staff by reducing a number of reports and refining procedures, while at the same time expanding the use of automated systems for the collection and reporting of management information. This has provided more staff time for direct delivery of services and closer training and supervision of VR&C staff.

We have continued to revise program operating instructions. Approximately 90 percent of the VR&C operations manual has been completed. Part of the manual has been released to field staff and part will be released soon. This material was used in draft form to conduct the regional training workshops last year and is helping to assure uniformity of rehabilitation services to disabled veterans.

During Fiscal Year 1987, implementation of a computer assisted guidance information system was begun by providing funds for hardware and software to selected field offices. This system is not yet fully implemented and disseminated. Using personal computer programs, it provides up-to-date educational and career guidance information, and testing during the rehabilitation counseling process. We are currently reviewing an additional computer system designed to more objectively assess the impairment of a veteran's capabilities caused by his or her disability. Both systems, if successful, would improve delivery of services by enhancing the evaluation process and the planning of rehabilitation services.

VR&C field staff have been challenged by their workload and are working vigorously to provide quality services within reasonable time frames. Our workload indicators show that the number of applicants and program participants has stablized and is expected to remain about the same for the next several years. We have done our best to retain qualified staffing at a level which will meet service needs and we are exploring ways of improving both quality and timeliness through reductions in paperwork and utilization of computer assistive devices and systems to speed some of our processes.

Timeliness of rehabilitation service delivery is essential if disabled veterans are to be assisted when they are well motivated to pursue the rehabilitation process. Over the past 3 years, we have concentrated our efforts on improving the timeliness, as well as quality, of rehabilitation casework.

VR&C staff assist veterans in acquiring suitable employment as a part of the chapter 31 program. The number of days for the average veteran to acquire such employment after becoming job-ready was 233 days in Fiscal Year 1985 and is now 299 days. I should add here that the minimum number of days in employment service is 90 days, since a veteran is provided post-employment services for that minimum period prior to being declared rehabilitated. We expect improvement in timeliness of services because of the implementation of the Computer Assisted Information System (CAIS), the implementation of the chapter 31 automated payment system (Phase II), and the combined effect of the ongoing initiatives previously addressed here today.

This concludes my testimony on the chapter 31 program, Mr. Chairman. I would now like to briefly summarize services provided under chapters and authorities other than 31.

The VA provides comprehensive counseling services to assist nondisabled veterans, servicepersons and other eligible persons who hope to use their educational assistance and benefits. Services are available at more than 100 locations nationwide, including VA regional offices, outbased locations and contract counseling centers.

Counseling services are authorized under almost all education programs administered by the VA including chapter 30, the Montgomery GI Bill-Active Duty program; chapter 106, the Montgomery GI Bill-Selected Reserve program; chapter 32, the Post-Vietnam Era Educational Assistance program (VEAP), chapter 34, the Veterans Educational Assistance program; chapter 35, the Survivors' and Dependents Educational Assistance program; and the Veterans Job Training Act (VJTA) program.

There appear to be two trends in the use of counseling services by veterans and dependents:

1. Overall use of counseling services has decreased. Counseling services requested by veterans and dependents in the programs described above have declined from approximately 15,660 in Fiscal Year 1985 to 11,685 in Fiscal Year 1986 and 10,116 in Fiscal Year 1987.

2. Veterans in the chapter 32 contributory program and the chapter 30 program appear to request counseling at a lesser rate than veterans and dependents in other programs. While veterans in the former programs constitute nearly a third of all participants in VA education programs, they accounted for only 5 percent of veterans counseled during Fiscal Year 1987.

Public Law 98-543, the Veterans' Benefits Improvement Act of 1984, established two temporary programs of vocational training and rehabilitation, one for certain veterans awarded VA pension and the other for certain service-disabled veterans awarded additional compensation because of a rating of IU (individual unemployability). These programs run from February 1, 1985, through January 31, 1989. We have implemented the provisions of both programs.

Mr. Chairman, this concludes my testimony. I will be pleased to respond to any questions you or members of your Committee may have.

REPORT

VOCATIONAL REHABILITATION AND EDUCATION SERVICE

EMPLOYMENT SERVICES TASK FORCE

1. Background. The Veterans' Rehabilitation and Education Amendments of 1980 (Public Law 94-466) amended VA's vocational rehabilitation program, which was established in 1943 by Public Law 78-16. Title I of Public Law 98-466 expanded the program's purpose to provide for all services and assistance necessary to enable service-disabled veterans to achieve maximum independence in daily living and, to the maximum extent feasible, to become employable and to obtain and maintain suitable employment.

Public law 98-466 significantly altered the vocational rehabilitation program's purpose and operations. Included was the requirement to provide chapter 31 participants with a full range of employment services, such as (1) preparing individualized employment assistance plans for program participants at least sixty days before completion of training, (2) following up with rehabilitated veterans to determine their employment status and employment assistance needs, and (3) providing direct or indirect employment assistance depending on the veterans' needs.

Since implementation of the new law, both VR&E Service appraisals of all stations and IG and GAO surveys of VR&C field operations suggest that we have not adequately implemented the requirements to provide direct employment services and comprehensive extended evaluations. Specifically, fifty-two regional offices were surveyed in the three year period ending March 1984. Thirty-seven percent were found to be deficient in the provision of employment services. The 1984 GAO study of VR&C's employment assistance confirmed these findings.

2. Employment Services Task Force. Clearly, the most significant provision of Public Law 96-466 was the targeting of employment as the goal of rehabilitation. The VR&E Service's

primary focus has been to implement the employment assistance provisions of the law during a time period in which the total number of veterans requesting services has progressively expanded and staffing has decreased. While these efforts have ben successful in providing employment assistance services to veterans, an acceptable level of quality has not been achieved.

The VR&E Service Employment Services Task Force, a group of central office vocational rehabilitation program staff and staff from three field stations, was formed and charged with the responsibility of identifying and addressing problems that impede the effective delivery of employment services to chapter 31 participants. The Task Force met at VA Central Office on two occasions, November 2-6, 1987, and February 1-5, 1988. The Task Force, with input from 11 regional office VR&C Divisions, identified 36 problems judged to impede the effective delivery of employment services. (See Appendix C.) The Task Force then proceeded to analyze the problems with respect to issues to be addresses and recommended solutions. (See Appendix B.) Many of these recommended actions will contribute to solving more than one problem. These recommended actions have been selected because they can be implemented with existing resources in a relatively short period of time.

3. Implementation. A detailed plan to implement the 18 recommended solutions is being prepared.

Appendix A

Employment Services Task Force

Membership

Nancy Hayward
Vocational Rehabilitation Specialist
Atlanta Regional Office

Wayne Otts
Vocational Rehabilitation Specialist
Phoenix Regional Office

George Pannebaker
Counseling Psychologist
Hartford Regional Office

Bob Lawson
Vocational Rehabilitation Consultant
Operations and Program Coordination, VACO

Hank Jurkowski
Vocational Rehabilitation Consultant
Policy and Program Development, VACO

William Jayne
Program Analyst
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Appendix B

Summary of Recommended Actions

1. Prepare a circular that encourages the use of work evaluations and extended evaluations to assess more realistically the veteran's motivation to work. The circular would require counseling psychologists (CP's) to compare the veteran's current level of compensation (including Individual Unemployability and Social Security Disability Income where applicable) to probable income levels to be generated in employment objectives under consideration. The intent ot this action would be to improve the initial evaluation process by CP's and, in turn produce more realistic rehabilitation planning.

2. Develop and issue for use a new form for the Individualized Written Rehabilitation Plan (IWRP)> The form should be flexible and non-restrictive in terms of the space allotted and the use of a computerized format should be investigated. The form should address the issue and facts considered in relation to eligibility for services and how each issue is to be remedied. The remedial services employed should thus provide a logical framework for understanding how the veteran's objective was developed. The form should also encourage modification and amendment as the veteran's needs change during the course of rehabilitation. Overall, the form should be designed to encourage creativity and comprehensiveness. Training should be provided to staff in the use of the form and the need for more creative, comprehensive and flexible training.

3. Prepare a circular that requires field staff to include basic "Job Readiness" objectives in the IWRP and provides guidance on defining "rehabilitated to the point of employability." Such guidance would emphasize that the veteran is not rehabilitated to the point of employability until he or she has completed certain job readiness tasks and is ready to seek actively employment. Thus, the Employment Adjustment Allowance would be paid when the veteran is actually rehabilitated to the point of employability rather than when he or she simply completes training. (38 C.F.R. §§ 21.190 (d)(1) and 21.268 (a).

4. To improve the quality of documentation, develop and direct the use of captioned report formats and a new three-part CER folder by VR&C staff. Without requiring the repetition of basic facts and issues on each report -- a process that would be burdensome and self-defeating -- the new report should require documentation of actions, services and observations relative to the facts and issues considered when the veteran was found eligible. For example, the form might include a caption such as

"Status of Primary Disability" which would require the case manager to address that salient issue without repeating the basic facts of the type and extent of disability each time. The new three-part CER folder would contain rehabilitation casework on the left side, evaluation and planning casework on the right side and awards and other financial and documentary paperwork in the center.

5. Encourage the use of case staffing throughout the vocational rehabilitation process. This should be accomplished through a number of actions including emphasis on case staffing at opportunities for training such as the monthly VR&C conference call, the VR&C Officers Conference and regular survey visits.

6. Develop new, more rigorous qualification (hiring) standards for both CP's and VRS's.

7. Work to require independent behavior on the part of each veteran in the program by assigning specific job readiness tasks to them throughout the process and emphasizing that job seeking is ultimately the veteran's responsibility. The VA assists but just as the veteran has the right to decide whether to accept a specific job offer, securing the right job is ultimately the individual's responsibility.

8. Require that, at the time of the VST's last supervisory contact during the veteran's training period, VRS and the veteran must specify a date, time and place for the first supervisory visit following the completion of training. VR&E should consider the use of a VA "How to Find a Job" step-by-step job hunting manual. The manual would include coupons that the veteran must submit at predetermined intervals showing that certain tasks have been accomplished, e.g., resume completed, registered with job service, etc. Veterans will be considered "employable" only after showing that they have completed the fundamental job search steps provided in the job hunting manual. Only then will they receive the employment adjustment allowance.

9. Through VR&C conference calls and other training opportunities, encourage strict use of the monthly employment service case review (DVB Circular 28-87-4). Also emphasize that the post-employment follow-up is an essential employment service necessary to determine whether the veteran is truly rehabilitated and to provide important services to ensure that the veteran is able to overcome difficulties encountered on the job.

10. Include objective measures of the quality of the program (such as employment outcomes and QRS indices) in the performance standards of all VR&C staff.

11. Designate one person in each VR&C Division to serve as the coordinator of employment placement activities. This could be either a collateral or exclusive duty.

12. Improve staff training through support for both VA and non-VA training activities. In addition, develop specific VR&C Officer and CP training programs.

13. Require VR&C Divisions to submit to Central Office a monthly report of all rehabilitated cases including a copy of VAF 28-1905d summarizing the facts of the rehabilitation and the rationale for the declaration.

14. Develop alternative program success outcomes and publish in a DVB circular. A veteran who receives training, qualifies for employment in his or her vocational objective but chooses to accept higher paying employment in an occupation that is considered unsuitable could be counted as a "successful participant," if not "rehabilitated."

15. Consider setting realistic limits for caseload size. These limits should be flexible and allow for consideration of the complexity of the cases. Also consider the hiring of VRS aids or assistants (GS-6 or GS-7) to assist with paperwork and other tasks.

16. Conduct research to assess the complexity of the Chapter 31 caseload. It is widely accepted that the caseload is more complex than it was ten years ago. If this impression is accurate, we should develop information that explains how the caseload is more complex so that new practices and policies can be developed to deal with the challenges associated with it. It is also widely held that DVB management is unaware of the problems associated with this increased complexity. The research should be widely disseminated and presented to DVB management in such a way as to gain their support for necessary corrective action.

17. VR&C, VR&E, and DVB management must take every opportunity to communicate to Regional Office Directors the importance of suitable emp[loyment in the Chapter 31 program and encourage them to provide all necessary support.

18. Develop a specific five to ten year development plan (goals and objectives) for the Vocational Rehabilitation and Counseling program and communicate the plan and progress toward achievement of the goals and objectives to all staff.

Appendix C

VOCATIONAL REHABILITATION AND EDUCATION SERVICE

Employment Services Task Force

Problems Judged to Impede the Effective Delivery of Employment Services

1. Time constraints.
2. Failure to contract for employment services with "for profit" organizations.
3. Current policy governing the payment of employment adjustment allowance is a disincentive to veterans.
4. Disincentives to employment, e.g., money, lack of motivation.
5. Geographic isolation of veterans needing employment services and follow-up.
6. Lack of VR&C Officer support for employment services.
7. Failure to measure effectively the delivery of employment and follow-up services.
8. Lack of training for professional staff, e.g, job analysis, job modification, job development, and placement techniques.
9. Failure to have a designated person responsible for coordination of employment activities.
10. Employers lack information on disabilities and disabled/handicapped people, i.e., functional limitations, special hiring programs, etc.
11. Economic conditions in some areas are too poor to allow job development and placement (relocation services).
12. Failure to provide training adequate for job market.
    - 12a. Failure to provide training to chapter 31 participants adequate for the job market.
13. Poor evaluation services with poor, unsuitable employment objectives.

14. Lack of contact with veteran from the time training is completed to the initiation of employment services.

15. Veterans are not motivated to work.

16. Lack of post-employment follow-up.

17. Lack of travel resources, ie., GSA cars, employee travel funds, etc.

18. Lack of communication and cooperation between CP's and VRS's.

19. Paper work burden for certain special employment initiatives, e.g., self-employment.

20. Failure to focus on employment at the beginning of the VR process.

21. Lack of creativity (comprehensiveness, flexibility) in IWRP planning.

22. Failure to adjust IWRP to account for veteran's changing needs and circumstances.

23. Failure to network with federal, state, local, and community organizations.

24. Unrealistic standards to declare a veteran "rehabilitated."

25. Failure to adequately document the veteran's needs, services provided, and the results.

26. Threat of political pressure and/or other types of pressure from veterans.

27. Increasing complexity of residual caseload.

    27a. Tough population (PTSD, NP, TBI. multiple disabilities, educationally disadvantaged, etc.)

28. Insufficient incentives for staff to provide effective employment services.

29. Streamline existing use of forms and procedures (1905d). Use a form with a "progress notes" type of format which allows for chronological report of veteran's progress.

30. Weak supervision by case manager.

31. Overdependence of veterans on VR&C staff for employment assistance (separation anxiety).

32. Failure of the system to view rehabilitation as a team effort.

33. Failure of VA Central Office and Regional Office management to provide a positive rehabilitation environment.

34. VR&C staff morale is weak.

35. Inter/intra DVB, VR&C coordination and cooperation is weak (DVB/DM&S).

36. Poor caseload management breeds bad morale (high-low imbalances).

Statement of Mary Joan Willard, Assistant Professor of Rehabilitation Medicine at Boston University School of Medicine, and Director of Helping Hands: Simian Aides for the Disabled, Inc. Given before the Senate Committee on Veterans Affairs concerning S.2207, a bill to authorize the Administrator of Veterans' Affairs to provide assistive animals to certain veterans.

June 16, 1988

Introduction

I am Mary Joan Willard. I am a behavioral psychologist on the faculty of the Department of Rehabilitation Medicine at Boston University School of Medicine. At the medical school I do research on the training of capuchin monkeys to serve as aides for quadriplegics. I am also Director of Helping Hands: Simian Aides for the Disabled, Inc., a non-profit organization which seeks to implement research results and place trained capuchin with quadriplegics across the country.

Mr. Chairman and Members of the Committee, I want to thank you for the opportunity to present my views concerning S.2207, introduced by Senator Frank H. Murkowski. This bill will amend Title 38, United States Code, to specifically authorize the Administrator to provide assistive animals to certain quadriplegic veterans. I will proceed by summarizing my remarks. I ask that my written text be presented in its entirety for the record.

Background on Quadriplegics

Recent medical progress has permitted the survival of very severely disabled people who, although totally paralyzed, have normal cognitive and communication skills. In many cases, severely disabled individuals also have a normal life expectancy. The most dramatic example is the high level spinal cord injured quadriplegic who is paralyzed, in varying degrees, from the shoulders down. As of 1985, there were at least 90,000 spinal cord injured quadriplegics in the United States. Eighty-two percent of them are male and most are young. Sixty-one percent were between the ages of 16 and 30 at the time of their injury (Spinal Cord Injury: The Facts and Figures, 1986).

To live outside of a chronic care institution, a high level quadriplegic typically requires a minimum of four to six hours a day of human help. The disabled individual usually receives this help from one or more family members who must make drastic changes in their own lives to provide it, and/or from paid personal care attendants (PCA). The relative or PCA assists with tasks such as bathing, dressing, bowel and bladder routines, household tasks, and transfer into and out of a wheelchair.

In addition to these essential tasks, which are usually performed in the morning and again at night, a high level quadriplegic may require help to perform countless small tasks during the course of a day. Putting a book or magazine on a reading stand, placing a cassette into a tape recorder, getting a drink, eating a meal, and retrieving a fallen mouthstick are all tasks that may require assistance.

Few quadriplegics have families that can provide assistance throughout the day, and fewer still can afford full-time paid attendants. Many quadriplegics simply do without. These individuals are surviving, but the quality of their lives leaves room for a great deal of improvement.

Feasibility of Monkey Helpers

At the age of 18, Robert was paralyzed from the shoulders down as the result of an automobile accident. One year after the accident, Robert began to live independently with the aid of a personal care attendant. His live-in attendant worked full-time in a nearby hospital, so Robert remained alone in his apartment approximately nine hours a day, five days a week.

In November of 1979, Robert began to participate in a pilot project to test the feasibility of simian aides. Since then, his helper has been a six pound female capuchin named Hellion. Robert communicates his needs to Hellion by aiming a small harmless laser pointer at the object he wants her to manipulate. The laser is mounted on the chin control mechanism of his wheelchair. Robert points it by gripping a small stick in his teeth. He uses the laser beam plus a verbal command to indicate what Hellion is to do with the object. When Hellion has completed a task, Robert rewards her with both verbal praise and a treat from the reward dispenser mounted on his wheelchair. Although his monkey occasionally makes mistakes, her overall task reliability is 94%. Chores which Hellion and other monkeys perform include transferring pre-packaged food or drinks from a refrigerator or microwave over to a feeding tray. The monkey will properly position and open containers. Monkeys can place a tape into a tape recorder o r a cassette into a VCR. Monkeys can retrieve a fallen mouthstick (an instrument use to turn pages, type, or dial a phone) and place the correct end in their owner's mouth. They can select a book indicated by the laser beam pointer and position it on a reading stand. They can turn lights on or off, or use a rag to clean up spills. Because they can move small objects from place to place following the laser beam, the owner can direct his monkey to place a TV remote control where convenient, or throw wastepapers in the trash. The monkeys will come when called, and return to their cage, locking the door behind them when given a cage command.

Between 1981 and 1987, ten additional high level quadriplegics received simian aides. Each placement functioned as a mini-experiment as new types of living situations, training techniques, and methods of placement were attempted. Although most quadriplegics use the standard repertoire of tasks described above, behaviors that have been custom trained include repositioning a quadriplegic's arm that has fallen off the wheelchair laptray, turning pages of a newspaper, scratching annoying itches, and repositioning computer printout paper so that a quadriplegic can flip through the pages with a mouthstick.

Species of Monkeys

Cebus monkeys are commonly called capuchins or organ grinder monkeys. The genus name is Cebus, and there are four species and 39 subspecies within that genus. Cebus monkeys were selected for this role because of their intelligence, small size, and ability to manipulate objects. The phlegmatic temperament of Cebus apella results in a longer attention span - a valuable asset in training. Of equal importance is the quality of the companionship they can provide. Adult Cebus apella will sit quietly in their owner's lap or look out the window for hours at a time.

Control of Destructive Behavior

Curiosity will lead these monkeys to climb on bookcases and tables, open cabinets, and empty trash cans. They may also get into cleaning supplies or medicine which can be toxic. To keep them from destroying someone's home and protect them from harm, a system was devised to teach them to avoid certain pieces of furniture or areas of the house. White 1-inch circular stickers are pasted on all off-limit objects. Several stickers on the side of a desk, for example, mean the desk and everything on top of the desk cannot be touched.

If a monkey breaks the rule and touches a stickered object, s/he is given a warning tone. If s/he continues to disobey, s/he is given a tone plus a 0.5 second shock to his/her tail. The tone/shock unit is a smaller modified version of the tone/shock collars used in dog training, and is worn on a belt around the monkey's waist. The quadriplegic owner can control it from his/her wheelchair.

Because the shock is intermittently paired with the buzz, the buzz becomes a conditioned aversive stimulus, and by itself acts as a strong deterrent. It is not unusual for some monkeys, once they become familiar with the disabled person's home, to go without shock for 9 months or more. Other monkeys who tend to test the "sticker rule" may need to be reminded with shock every few weeks to maintain the avoidance system.

Monkey Aggression

Even very tame capuchins have been known to attack unfamiliar humans. Within a few months of moving into a home, a monkey will behave toward the household members as if they are part of her troop. The quadriplegic owner generally is at the top of the hierarchy, with relatives and attendants each assigned a rank. Visitors and those at the bottom of the hierarchy can never be totally certain as to when the ordinarily playful, affectionate monkey might view them as a threat, and bite.

To eliminate the possibility that any capuchin aide might harm someone, these monkeys undergo a full mouth teeth extraction when they reach maturity (3-1/2 to 4 years of age). This operation has for many years been commonly performed on monkeys used by organ grinders without affecting the animal's diet (monkey chow is softened). All of the monkeys placed through this project have undergone full mouth teeth extractions without any deleterious effects on their health or subsequent behavior, or any perceptible long-term discomfort. Capuchins almost never use their nails as weapons, and since 1979, no one has ever been seriously injured by a simian aide.

Psychological Factors

Although the primary goal of this project is to increase the ability of a quadriplegic to perform the tasks of everyday life, this unusual intervention has had a strong psychological impact on disabled participants.

Most high level quadriplegics lead very restricted lives, often spending weeks at a time within the confines of their homes. An affectionate, responsive and entertaining capuchin can be a very welcome addition to an unstimulating environment. One owner described the monkey's place in her life as somewhere between that of a pet and a child.

In addition, ownership of a monkey conveys a certain status on the recipient. Monkeys outside of zoos are rare. Monkeys who perform chores like small humans and readily play with visitors are even more unusual. Quadriplegics acquiring a monkey aide have reported that overnight they feel as if they became a mini-celebrity in their neighborhood. Ownership of a monkey provides an obvious and interesting topic of conversation. It can minimize the discomfort the able bodied feel when relating to the disabled, and allow for the more natural development of friendships. Considering the circumstances in which many quadriplegics find themselves, the importance of these social factors cannot be overestimated. For psychological reasons as well as financial, it's fortunate that these monkeys have a life expectancy of 30 years.

Helping Hands: Simian Aides for the Disabled. A service organization

By 1982, it was clear that functionally and psychologically, simian aides were effective for at least some quadriplegics. Further research was needed to refine the procedures by which they were socialized, trained, and placed, but the basic concept proved to be feasible. A television program showing Robert and his monkey brought in hundreds of phone calls and letters from disabled people interested in obtaining a trained monkey. A non-profit organization called Helping Hands: Simian Aides for the Disabled, Inc. was established to meet the goal of providing monkey helpers to quadriplegics - much like guide dogs are now offered to the blind.

For the first two years, Helping Hands consisted of a small group of volunteers with an annual budget of about $3,000. In 1984 and 1985, however, fund raising efforts were more successful. What follows is an account of progress to date.

Sources of Cebus Apella

As of April 1988 Helping Hands' breeding colony was located on Discovery Island at Walt Disney World in Florida. The facility was built and will be maintained by Disney as a contribution to Helping Hands. The Disney colony of 63 breeders will eventually contain 80 animals and is expected to produce 25 babies per year. Other sources of monkeys include donations from private individuals and other breeding facilities. Helping Hands has also become a safe haven for stray monkeys and for those that have been confiscated by various government agencies.

Foster Homes

Trial and error testing has demonstrated that early socialization is essential for the production of affectionate and humanized primates. When baby monkeys are six to eight weeks of age, they are placed with foster families, who volunteer to raise them in their homes for a period of about 3 years. Volunteers agree to spend 10 hours a day with their primate babies during the first six months. Foster parents literally carry their babies on their arms as they go about their daily business. Older animals require less intensive contact, but a minimum of four hours each day must still be spent interacting with the monkey outside of its cage. As of Spring, 1988 there are 65 young monkeys being socialized by volunteers. Over 100 additional families have passed the screening process and are awaiting the opportunity to foster animals as they become available. A part time foster care director screens, coordinates and monitors the placements.

Training

Socialized monkeys who are at least 3 years of age are sent to the Helping Hands program at Boston University School of Medicine for their training. A standard repertoire of obedience and helping tasks takes about six months to teach.

Training is done by students two hours a day, 5-6 days a week. Not only is student labor relatively inexpensive, but students are developmentally well suited to the job demands. They have energy, dedication, and patience, and are often thrilled with the opportunity to train primates. By the time the novelty of the job wears off, many are about to graduate and move on to other types of work.

Evaluation of Quadriplegic Candidates

Evaluation of interested candidates consists of an initial telephone interview, followed by a home visit to those who seem most suitable. A videotape is made of the interview with the disabled person, his/her attendant(s), and other household members. Details of the quadriplegic's environment, equipment, and physical abilities are also recorded and reviewed back at the laboratory, to help custom train a monkey to meet specific needs. Individuals are selected to receive a monkey based on their needs and characteristics, as well as the needs, abilities, and personalities of the specific monkeys in training at that particular time.

Placement

During the actual placement, a trainer travels to the home of the quadriplegic and works with that individual, his/her family, and the monkey for 4-7 days. A support person is hired to come in one hour a day for the next 6-8 weeks, to help the monkey develop a routine with the disabled person in the new home environment. By the end of that period, the monkey's tasks are usually transferred and under the control of the new owner. A complete social adjustment on the part of the monkey and the household members may take up to six months.

Who is Appropriate for a Monkey Helper

Approximately 74% of quadriplegics or 66,600 disabled individuals in this country are physically appropriate for a monkey helper. Of those who are physically appropriate, it is estimated that 10-25% or 6,600 to 16,600 individuals fit all of the selection criteria. These criteria are listed in Appendix A of this report.

Funding History

Research support to explore the feasibility of monkey helpers came initially from the Paralyzed Veterans of America, then the Natural Science Foundation and it is currently provided by the Veterans Administration Department of Rehabilitation Research and Development. Private Foundations, most notably the Dodge Foundation and the Educational Foundation of America have also provided support.

The Veterans Administration research grant is administered by the Boston University School of Medicine. M.J. Willard, a behavioral psychologist on the faculty of the Department of Rehabilitation Medicine is the principal investigator on that grant. Dr. Willard is also Director of Helping Hands: Simian Aides for the Disabled, Inc., the service-oriented component of the project. Negotiations are underway to formalize the affiliation between Helping Hands and Boston University. By the summer of 1988 it is expected that resources from both organizations will be used in a service-oriented program that will place monkeys with quadriplegics across the country. It will function similarly to a guide dog program.

Cost Effectiveness

Based on preliminary cost assessments for the placement of 50 animals per year, the cost per placement is 11,770. With an average 20 year working career for each placement, the annualized costs including maintenance of the placement are $778.

If the placement results in the reduction of just one hour per day of attendant time for the average quadriplegic, the program will yield a net savings of $3,712 for each placement.

Cost to Quadriplegic Recipient

There are nine guide dog schools in this country. They have been so successful in raising funds that any appropriate blind candidate in the United States can receive a guide dog for a token fee of $150. The actual cost of providing the dog is around $8,000 and is covered by private contributions. Like the blind, quadriplegics are rarely in a position to afford the costs of an assistive animal. Support via third party payments, corporation and foundation sponsorship and private contributors will also be sought to offset the placement expenses. Ideally, appropriate quadriplegic candidates will be charged only a nominal sum for a monkey helper.

Other Programs

Although Helping Hands is currently the only service organization in the United States to train and place simian aides, rehabilitation centers in Israel, Belgium, and Canada have begun their own programs with assistance from Helping Hands. This project has the potential not only to help American quadriplegics, but to serve as a model for similar efforts in other parts of the world.

S.2207

Eleven years of effort and over a million dollars have gone into research on the feasibility of monkey helpers. S.2207 will enable certain quadriplegic veterans to reap the benefit of that investment. I want to take this opportunity to thank Senator Murkowski for his recognition of the merits of this program through the introduction of S.2207. His efforts on behalf of veterans and the nations disabled individuals in general are greatly appreciated. I would also like to thank Chairman Cranston for his interest in this legislation as demonstrated through the scheduling of this hearing, and for allowing me the opportunity to testify.

Finally, I would like to thank the Paralyzed Veterans of America which first took a chance on this novel research concept in 1979. Their initial financial support and continuing advice and encouragement have made the development of the Helping Hands monkey possible.

Appendix A: Selection Criteria for Monkey Aide Recipients

1. **At least one year post-injury**
   A quadriplegic individual should have sufficient time for his/her life to stabilize after an injury.

2. **A reliable attendant situation**
   Since the attendant will be the primary caregiver to the monkey, it is critically important that the attendant also be involved in the decision to receive a monkey.

3. **Majority of time spent at home**
   A monkey is trained to work in the home environment and it is unfair to leave the monkey alone on a regular basis. As such, individuals who go to school or work full-time outside of the home are not ideally suited to having a monkey aide.

4. **Sufficient motor ability to control an electric wheelchair**
   In order to perform tasks with a monkey aide, an individual must be capable of independent wheelchair mobility to move about the home environment. The same motor ability used to activate a puff-sip, hand, or chin control unit will be utilized to control monkey communication equipment.

5. **Functioning electric wheelchair**
   Much of the equipment used to communicate with a monkey is attached to a wheelchair. For this reason, the wheelchair which will be used on a daily basis must be fully function functioning before an individual can be selected to receive a monkey aide.

6. **A need/desire for independence**
   If at any time a monkey becomes merely a "pet" for the quadriplegic owner, the monkey must be returned to Helping Hands. There are too many people who wish to become more independent that are waiting for monkeys to help them realize their potentials.

7. **Unimpaired cognitive function**
   Individuals who receive monkeys must have good decision making skills, especially in situations when monkeys will occasionally "test the rules." The quadriplegics themselves must also be able to coordinate and monitor the daily care and health of their monkeys.

8. **Adequate verbal communication**
   Individuals must be able to give clear, consistent commands to their monkeys. This increases a monkey's

ability to distinguish one command from another.

9. **No small children in the household**
   Monkeys require a stable, uncluttered home environment in order to perform their tasks accurately and reliably. Young children make it difficult to maintain the structure needed by the monkeys. In addition, young children are capable of doing many of the tasks a monkey can do, and more.

10. **Enthusiasm**
    This comes in many forms... desire to become more independent; willingness to adapt one's home environment to accommodate a monkey; willingness to drill with the monkey in her tasks on a daily basis during the adjustment period after placement, etc.

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TESTIMONY FOR THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

JUNE 16, 1988

PRESENTED BY

TONI SULLIVAN, ED.D.
CHAIR, DEPARTMENT OF NURSING
UNIVERSITY OF SOUTHERN CALIFORNIA

American Association of Colleges of Nursing
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Good morning, I am Toni Sullivan, Dean of the School of Nursing at the University of Southern California. I am pleased to present today on behalf of the American Association of Colleges of Nursing. Our organization represents approximately 400 senior colleges and universities that have schools of nursing. We are pleased, Senator Cranston, that you have also been concerned about the current nursing shortage and the changing nature of nursing education and wish to respond to S. 2462, "The Veteran's Administration Health Care Personnel and Programs Act of 1988".

As you have noted in your presentation regarding S. 2462, the current nursing shortage is a multi-faceted problem. You and your colleagues are to be congratulated for providing a multi-faceted approach to solving the current nursing crisis.

Nursing is a vital part of any health care system, but is even more critical to the delivery of high quality health care in the acute care setting. Without a staff of highly educated and skilled nurses, the delivery of health care in a hospital will suffer. We applaud your efforts to enhance the environment in which nursing is practiced. The development of responsive pay and personnel management practices at the Veteran's Administration are vital to the recruitment and retention of qualified professional nurses. Perhaps of even greater significance are your proposals to create new and innovative practice opportunities and to create programs which foster enhanced collaboration between physicians and nurses. We believe that many of the issues surrounding retention of qualified staff are quality of professional life issues that can only be solved through development of collegial relationships with all members of the health professions.

We would especially like to comment, however, on the initiative to provide enhanced support of health professions education programs that collaborate with the Veteran's Administration. This initiative can provide invaluable support to both the nursing profession and the VA health care mission.

Nursing education is a labor intensive experience. Indeed, the major costs associated with education of nurses are faculty related. Students receiving clinical training must have intensive mentoring by clinical faculty. Nurses receive extensive clinical training as a part of their baccalaureate education experience. And, as part of their clinical training experience, students of nursing often care for extremely ill patients and provide invaluable services to the clinical facilities in which they train.

Our association is in fact completing a study of the costs and benefits associated with having students in a clinical training facility. We are only in the preliminary stages of data analysis, but we can say that our findings indicate that numerous benefits accrue to clinical facilities that support nursing education. Clinical faculty often are responsible for monitoring ten students. Each student may care for as many as four patients. This translates to enormous responsibility for a clinical faculty member. More pointedly, many of the benefits that accrue to clinical facilities are related to the expert clinical knowledge and skills that nursing faculty provide as a part of their clinical mentorship of students.

However, unlike medical education in which the costs of medical student clinical faculty are borne by the hospital, academic institutions assume the costs of supporting nursing clinical faculty. The continuing demands upon the resources of nursing schools makes curriculum innovation difficult. The development of joint efforts between schools of nursing and the VA would be extremely effective in assisting the schools of nursing to more effectively respond to changing curriculum demands. Grants for the support of clinical faculty in Veteran's Administration facilities would not only free up resources for alternate uses in the academic institution, but would also provide a direct benefit to the VA in the form of clinical nursing expertise and skills provided by the nursing faculty.

An additional benefit of enhanced collaboration between schools of nursing and the Veteran's Administration is the potential recruitment of future nursing personnel. Students who train in a medical facility that is providing innovative support to their nursing personnel often choose to begin their nursing career in this clinical facility. Clearly then, a side effect of the enhanced relationships between the VA and schools of nursing would be a ready supply of nursing personnel who recognize the value of employment in the VA health care facility.

We are also pleased that you and your colleagues recognize that any innovative health professions education initiatives must be undertaken through collaboration with the health profession's representatives. We have been especially concerned that members of other health professions have frequently attempted to superimpose their notions of what constitutes good nursing education or practice over the nursing profession, rather than attempt to discern how they might collaborate with the nursing profession. Indeed, current proposals by the American Medical Association to develop alternative bedside workers are illustrative of the overall lack of collegiality or collaboration which the medical profession has displayed towards nursing. Any health professions educational endeavor must be leveloped by consultation with the profession under discussion.

Senator Cranston, our association applauds your efforts in S. 2462. We, like you, recognize that the future of our health care system depends upon innovative and creative solutions to the current nursing crisis. We recognize the need to make both education and practice innovations to solve this complex problem. We offer our support in these efforts and stand ready to assist in the implementation of these initiatives.

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

TESTIMONY

Of The

AMERICAN NURSES' ASSOCIATION

On

VETERANS' ADMINISTRATION

HEALTH PERSONNEL AND PROGRAMS

Before The

SENATE VETERANS' AFFAIRS COMMITTEE

PRESENTED BY

GERTRUDE KEOUGH, R.N., M.S.N.

JUNE 16, 1988

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Mr. Chairman, I am Gertrude Keough, R.N., M.S.N., a retired Veterans' Administration (VA) Nurse, who previously served as Director of the VA Health Professional Scholarship Program. I now serve as a volunteer in nursing homes that service veterans. I would like to thank you on behalf of the 188,000 member of the American Nurses' Association (ANA) and its 53 constituent state nurses associations for this opportunity to address veterans' health issues, and health personnel related matters. I am also pleased to appear today, on behalf of the approximately 40,000 registered professional operating room nurses who are members of the Association of Operating Room Nurses (AORN). A significant number of our members are VA nurses. ANA has represented VA nurses in collective bargaining since 1967 through its state nurses' associations.

This hearing reflects the committee's continued commitment to the provision of quality nursing care for the men and women veterans of our nation. The committee has been instrumental in improving working conditions for nurses, guaranteeing nurses the right of collective bargaining, encouraging nursing career development, providing educational opportunities, promoting clinical nursing research and fostering the critical inclusion of nursing within the Veterans Administration's health care system.

ANA would like to thank the committee for the passage of several provisions of S. 9 (Public Law 100-322) which enhanced the ability of the VA to recruit and retain nurses. Your continued efforts demonstrate the committee's recognition of the seriousness of the VA's nursing shortage, its effects on veterans health care, and the need for long term solutions to address the problem.

After several years of health care staff reduction, a trend is emerging in the health care industry: a shortage of registered nurses. recently as two years ago the vacancy rate for registered nurses in U.S. hospitals was as low as 6 percent and many available jobs offered part-time employment only. Today, hospitals across the country are reporting numerous budgeted nursing vacancies. The vacancy rate has more than doubled between 1985 and 1986 (from 6.3 percent to 13.6 percent) according to data released by the American Hospital Association (AHA).

Current payment policies by the federal government and the private sector are creating situations in which patients are generally admitted only for the acute portion of their illness. While in the hospital, the average patient is more acutely ill then in past years, and requires a more intensive level of nursing care. This has placed an additional demand on nursing staff, who are now required to have far more sophisticated skills to perform physical assessments, monitor and utilize high technology equipment, teach patients and their families and prepare discharge plans.

Many hospitals overreacted to Medicare's prospective pricing system by cutting nursing budgets, laying off nurses, and halting recruitment efforts. Many of the nurses who were terminated shifted to other settings and positions, thereby reducing the supply of nurses available to hospitals. Hospital executives are now acutely aware that nursing staff levels are grossly inadequate. ANA believes that, as a result of these developments and trends, the average workload of registered nurses has increased markedly, has been largely responsible for the emergence of the current shortage of registered nursing personnel in this country.

The nursing shortage is critical because people in need of nursing care are seriously ill. Their care is complicated by factors of age, the presence of chronic illnesses affecting many body systems, the use of highly technological treatments, pressures for early discharge and the devastation of HIV infections. Veterans who require health care are no different than those who seek care in the private sector.

The surging demand for nurses, a major factor in the shortage, provides evidence that efficient, effective utilization of qualified, experienced registered nurses is needed to preserve quality of care within the limits of cost containment. ANA believes it is imperative that any solutions initiated to resolve the nursing shortage be directed toward the root of the problem, with careful consideration to the cost and quality of health care delivery and the changing needs of the health care system.

In order to alleviate the immediate shortage, ANA endorses the following two short range strategies:

1. Immediately increase the time that registered nurses spend with patients by reallocating resources and developing staffing to:
   - employ nursing assistants and licensed practical nurses to assist registered nurses in the support tasks essential to patient care;
   - change the salary and benefit structure to retain experienced nurses; and
   - help nurses who work part-time to return to full-time employment.
2. Quickly expand the overall pool of registered nurses who work

in hospitals and long term care facilities by:

- facilitating the educational mobility of LPNs and aides;
- increasing financial aid to career changers to complete accelerated RN programs;
- increasing financial aid to minority students; and
- increasing the number of work study programs.

The needs of patients in todays health care system require the care of a registered nurse. The nursing profession is committed to these short term strategies to alleviate the shortage of registered nurses while it seeks long term solutions to address the expected future need for nurses.

A shortage of registered nurses also often leads to inefficient use of hospital facilities. In some hospitals, for example:

- Patients are refused admission to intensive care units;
- Patients are admitted to intensive care units because of a shortage of medical/surgical nurses to provide care needed in those areas;
- Patient transfers may be delayed;
- Patients may miss, or be incompletely prepared for diagnostic tests; or
- Hospitals may be forced to close beds/units to admissions.

For example, the VA hospitals in the Atlanta, Augusta area have closed 125 patient beds because there are not enough nurses to provide care to veterans requiring hospitalization. The Manhattan VA had to limit its cardiac surgery due to a shortage of critical-care nurses. In addition, the Togus, Maine VA had to close a ward because of the nursing shortage.

We would like to offer the following views regarding health legislation currently before the committee.

S. 2462

The "Veterans Administration Health-Care Personnel and Programs Act of 1988" would ensure the continued maintenance and improvement of the health care needs of our nation's veterans and their dependents. ANA supports Section 4 which would authorize the Administrator to appoint employees to civil service positions, without regard to the civil service register process, who are newly graduated qualified health care professionals outside of Title 38 professionals who held a VA appointment while completing a clinical education program. We agree that such a measure would expedite the recruitment and retention of health care staff who are already oriented to the VA system. It can be anticipated that the VA will lose less of these VA trained individuals to a more competitive private sector because of the deletion of the tedious, time consuming civil service hiring processes.

Section 5 decreases the amount of time within which the Office of Personnel Management (OPM) can approve or disapprove special salary rates for Title 5 employees. ANA supports the reduction of administrative delays which hinder the ability of the VA to ensure adequate qualified staffing for direct patient care. These Title 5 health care employees provide needed support services, which if inadequate, increase the already overburdened staff nurses. Nursing must then assume those functions of support personnel when inadequate staffing exists, lessening the amount of time that nurses can provide direct nursing care to patients.

S. 2462 creates a grievance resolution process which parallels that available to Title V employees. The resoltuion of specified lesser disciplinary actions such as admonishments, reprimands, suspensions of 14 days or less, and transfers not involving loss of grade, would be used in cases involving Title 38 personnel, including the use of a negotiated grievance procedure involving an appeal to an arbitrator for those employees who are members of recognized bargaining units.

During the discussions of S. 9 last year, ANA and other employee representatives expressed concerns about the fairness and timeliness of Title 38 disciplinary actions as compared to Title 5. At that time, ANA testified before the committee that the disciplinary process should not make a distinction between seriousness of offenses. The proposed provision in Section 6 compromises the concept of a progressive disciplinary system. We do not believe that an employee's rights to due process are any less when lesser disciplinary actions are involved. It is the degree of penalty, not the extent of due process, which properly fluctuates with the seriousness of the infraction. Additionally, the employer often relies on a chain of lesser actions as a reliable indication of a more serious disciplinary problem which needs correction. Therefore, the employee must have a meaningful opportunity to challenge those "lesser" actions as they may become the substantive basis for later penalties. If the employee is denied due process on the lesser actions in the chain, she could be precluded from challenging their effect on more substantive actions, such as a discharge action.

Consequently, we ask the committee to ensure that all Title 38 employees retain their due process rights, regardless of the infraction, and take no actions in S. 2462 that would jeopardize those rights.

ANA wholeheartedly supports Section 8 which authorizes grants to assist implementation of cooperative arrangements between schools affiliated with the VA, designed to coordinate, improve, and expand the education of the non-physician/dentist, professional and technical health care personnel. The development and evaluation of new health careers, interdisciplinary approaches, and career advancement opportunities must be examined carefully.

We are especially concerned that new health careers may be seen by some as an answer to the nursing shortage. Introducing a new breed of health worker will only create more confusion, as well as accountability and liability problems, without addressing the real need, which is for more support systems for nurses. Nurses, who best understand their practice settings, must be centrally involved in defining and developing those systems.

The VA presently uses nursing assistants and licensed practical nurses to assist the registered nurse in providing care to patients. The utilization of support staff has meant delegating nursing care functions. Additionally, some treatment functions previously administered by nurses have been assumed by technicians.

Differentiating between levels of practice for the purpose of better utilizing nursing personnel is a very sound management and quality principle. Moreover, changes in health care are requiring more of nurses, which the profession has both anticipated and responded to in setting new standards for practice. The nursing shortage, caused in large part by the surging demand for nurses with the versatility, organizational ability, and breadth of clinical knowledge and judgment to operate in today's fast-paced, high acuity, complex health care environment, must be viewed as a compliment, not a condemnation. If anything, we are the victims of success, having produced a service much needed, though substantially underpriced.

However, ANA believes that any future development of new health practitioners may result in increased fragmentation of services. More and more coordination of services is required due to acuity of illness, chronic needs, and discharge planning. Patients may feel alienated by increasing levels of providers. The professional nurse, more than any other health care professional, is qualified to provide comprehensive, cost effective, and compassionate care by individualizing and coordinating patient needs with existing multi-disciplinary providers. However, increasing the types of providers will only serve to increase intervenors in the patient care process, which may decrease efficiency. Supervisory requirements of such personnel will increase managerial and planning workloads. With these considerations in mind, we believe the language in Section 8 requiring collaboration with the professions who carry out the functions for which new providers would be responsible is critical. Nursing must have authority and involvement over any individuals performing nursing functions. What the VA system needs is more nurses, not a new, lesser skilled practitioner. Any other approach will short change our veterans.

Upon review of the various pilot programs outlined in the bill related to recruitment and retention of registered nurses, ANA makes the following observations. Several of the mandated programs have been researched and are in existence in private sector facilities, as well as in some VA medical centers. Nursing research has already demonstrated the pluses and minuses of collaborative practice committees, expanded administrative and supervisory Chief Nurse roles, and patient care alternatives for registered nurses. The professional literature discusses these management and practice modes considerably. Therefore, we do not believe such programs need to be repeated.

ANA believes the VA's Nursing Service has the professional knowledge and experience to determine what is appropriate for nursing practice in the VA. ANA urges the Administrator to provide adequate levels of funding and administrative support and direction to allow nursing to implement its programs which are supported by existing nursing research. Additionally, we believe it is not the responsibility of the legislature to specifically designate nursing practice modes. Congress need only provide the Administrator with the requisite authority to implement programs and appropriate funding. Anything more would subject the VA's Department of Medicine and Surgery (DM&S) and Nursing Service to micro-management.

ANA does believe the study of the effects of increasing evening and night shift differential on recruitment and retention of nursing personnel has significant merit. However, we again point out that the authority to conduct such a program already exists. The Administrator does not need a legislative mandate to accomplish such recruitment and retention strategies. ANA believes that Congressional admonishment of the agency's oversight will motivate the administrator and buttress nursing initiatives.

S. 2463

The bill would improve VA care for veterans with mental illness, especially with service related conditions. It would establish the designation of centers of mental illness research, education, and clinical activities in up to five VA medical centers. ANA believes that such services are necessary to ensure that veterans receive comprehensive health care. The VA, health care professionals and the nation have been made more aware of the veterans mental health needs in the last few years. These needs emcompass drug and substance abuse, psychiatric needs of post traumatic stress and the increasing mental health needs of geriatric patients. Nursing has become expert in the treatment of drug dependence, rehabilitation and gerontology and will be valuable assets in the mental health programs. These proposed programs would instill renewed energy into the VA's mental health activities and address veterans' needs.

Finally, ANA would like to thank you for establishing a tuition reimbursement program for nurses pursuing courses leading to a bachelor or an advanced degree in nursing. The federal government predicts that by 1990, the demand for baccalaureate-prepared nurses will exceed the supply by 340 percent. The projected shortfalls by the year 2000 will be even greater. If these projections come to pass, it is obvious that a critical shortfall in registered nurses prepared with baccalaureate and higher degrees will be upon us before the next century.

Between 1980 and 1986, the percentage of baccalaureate nursing students studying full time increased by 12 percent while those studying part-time increased by 114 percent. This trend complements national statistics that report fewer than 50 percent of all college students are completing their baccalaureate programs in four years. Nearly 25 percent require more than five years to achieve the bachelor's degree (no doubt the necessity to remain employed while attending school because of the decrease in federal financial assistance has contributed to this situation). These data suggest that a much longer time than the traditional four years will be required to educate a baccalaureate-prepared nurse in the future. Therefore, ANA believes that tuition reimbursement will help to assure an adequate supply of appropriately educated VA nurses to meet the expected health care needs of the veteran. We urge the VA to seek continued and appropriate funding for such tuition reimbursement programs.

ANA supports the enhancement of the VA's authority to recruit and retain certain health care personnel. We also support the recent extension of the VA Health Professional Scholarship Program to any field of training or study in direct health care services. We believe that adequate numbers of the multidisciplinary team are necessary to ensure that nurses can function appropriately to provide quality nursing care. All too often nurses must assume the role of other providers to make up the deficits in patient care. ANA expects that the VA's commitment to funding nursing scholarships will not be diminished by such expansion.

In closing, ANA reiterates its commitment to assuring quality nursing care to our nation's veterans. As a profession, nursing has always responded to a health care crises, and we pledge to work with the VA to provide the nurses necessary to operate the VA health system. We hope that these hearings help maintain the ability of the VA to provide quality health care. Thank you again for the opportunity to present ANA's concerns and recommendations.

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Statement of
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Before the

U. S. Senate Committee on Veterans Affairs

June 16, 1988

Mr. Chairman and Members of the Committee, I am Claudette Morrissey, a Registered Nurse employed full-time as a Staff Nurse at the Veterans Administration Medical Center, Brooklyn, New York. I am here today as the President of the Nurses Organization of the Veterans Administration (NOVA) and I thank the Committee for the opportunity to appear before you. NOVA is a professional association of registered nurses employed by the Veterans Administration, the largest single employer of registered nurses in the United States. While I speak as the representative of NOVA it is my goal to reconfirm the need of Veteran patients for the nursing care provided by over 32,000 RNs in the 172 VA Hospitals and 200 outpatient clinics. This nursing care can be provided only when the VA is able to recruit and retain adequate numbers of Registered Nurses and other health care personnel. NOVA is very pleased to testify today at this very important hearing addressing legislation that will affect the care of veterans in VA hospitals and clinics.

NOVA is concerned about the national shortage of nurses and what that will mean to our nation's health care and particularly the Veteran patient. We are all aware of the predictions that by the end of this century the demand for nurses will be double the supply. Registered nurses are the constants in the hospital--we are there 24 hours every day and seven days a week. Nurses create and control the environment of healing. We are the observers, the monitors, the teachers, the clinicians who collaborate with the physician and other health care professionals in the care and treatment of hospitalized veterans. As NOVA testified last year the VA currently does not staff to its own staffing methodology guidelines. With the historic low staff to patient ratios in the Veterans Administration Hospitals, VA nurses are running at full speed when all the vacancies are filled. Overworked nurses are very poor recruiters to a profession. Many nurses report they discourage daughters, neighbors, children of friends and certainly sons from considering nursing as a career. Overworked nurses are poor recruiters for the VA system.

To address this problem of recruitment and retention of nurses in the midst of a national shortage, steps need to be taken. VA nurses have pointed the way in their responses to studies over the past 20 years. Blue ribbon panels and nursing researchers have pointed the way--what is needed now is action.

Retention of nurses already working needs to be our first concern. A cadre of satisfied, enthusiastic competent and caring nurses will be our best recruiters for the future.

NOVA is pleased to bring the perspective of working VA nurses to this hearing and will provide comment on the appropriate sections of the proposed legislation.

S-2462

Section 4 Appointment of VA trained graduates

When fewer than 6 percent of students who received their training and clinical experience at VA facilities take jobs at those facilities the VA may very well be missing an opportunity to hire health care workers. The waiver of the usual civil service hiring process may or may not increase the percentage hired. Students who affiliate are looking over the VA system just as the VA has the opportunity to observe them. Student nurses who affiliated with the VA have frequently stated they did not choose to seek employment at the VA because "VA nurses work too hard." NOVA does not oppose the waiver of the civil service hiring process but we believe the key to attracting and hiring the VA trained graduates will be the creation of a favorable work environment.

Section 5 Special Salary Rates

NOVA supports the proposed efforts to speed up the approval of the special salary rates. For both title 5 and title 38 personnel the staffing situation often is desperate when facilities first look at this as an option. The lengthy process of data collection, and multilevel review means that there is a significant lag time. The failure to give employees on the special salary rates the annual federal employee Cost of Living Adjustment further compounds this problem. NOVA strongly supports giving employees on special salary rates the COLA and believes this will help prevent the movement from one staffing crisis to another.

Section 8 Assistance to Public and NonProfit Institutions of Higher Learning

NOVA endorses the concept of this proposal. The schools of nursing need the support to develop innovative programs that will reach out to corpsmen, paramedics and others with health care training and no clear career path to pursue a nursing education. We hope this can be done in conjunction with employment at the VA. Seriously ill veterans are in need of nursing care, care that is complicated by factors of age, chronic illness, multi-system involvement, high-tech treatments and the pressure for early discharge from hospitals. The need for this level of nursing care frequently continues after acute care and into long term care facilities and the home. The patient acuity mandates that nurses be at the bedside. Since nursing's major occupation has always been and will continue to be providing nursing care at the bedside, NOVA supports this effort to increase the numbers of nurses with innovative programs. NOVA also supports the efforts to increase the supply of other scarce health professionals and established health occupations. NOVA cautions against the establishment of additional levels of health care workers under the provision of "development of new health careers". NOVA agrees with our nursing colleagues outside the VA that new categories of health care technicians are "unnecessary, duplicative, and costly and can only serve to further fragment patient care."

NOVA does not wish to see nurses in the VA forced to abandon patient care. NOVA does want to see an end to the use of nurses for non-RN work. Hospitals need to stop viewing nurses as the all purpose employee who can stand in for anyone--a secretary, a nurse's aide or whatever else is needed!

In the shortages of the 1970's and the 1980's VA nurses have called for support services. To attract and retain sufficient numbers of patient support workers the VA will have to look at a pay structure that makes it financially more rewarding to care for the VA grounds and buildings than to work in the occupations that support the care of patients.

VA nurses say give us improved and consistent support services and as nurses we will care for the patients.

Section 9 Pilot Program of Pay and Personnel Management Practices

A Collaborative Practice Committees

NOVA is pleased to see a pilot project that will address this issue. At a recent meeting of the Health and Human Services Secretary's Commission on Nursing, Elizabeth Draper, RN of Apache Medical Systems presented her study which showed that close collaboration of RN's and physicians makes a difference in the outcome of fewer than expected deaths.

NOVA has testified in the past that this collaboration would improve professional and job satisfaction for nurses and welcome this confirmation that it is also good for the patient.

B Expanded Role for the Chief Nurse

NOVA has spoken earlier of the need for support services and believes this pilot study may point the way to assuring these supportive services function in a responsive fashion to patient care needs. Hospitals in the private sector have had success with this model.

C Creating New Nursing Models for Furnishing Care

NOVA thanks you Mr. Chairman for your confidence in nursing within the VA. The opportunity to create new models for delivering patient care may help VA nursing assume its rightful place in the development of innovative practice models.

D Pay Differentials

The rotation of shifts has long been one of the more onerous aspects of working as a nurse. Large enough economic incentives have not been tried to attract sufficient numbers of volunteers to work unpopular shifts as is done in other 24 hour a day industries.

VA nurses have indicated in past studies that this is a big issue for them. NOVA thanks you for including this pilot study and hopes the VA will act quickly to utilize the authority they have in place.

In addition to the legislative proposals before us today NOVA would like to encourage the support of the authority for the VA to hire retired military nurses without retired nurses losing their military retirement pay.

NOVA also supports the authorization of premium pay for licensed practical nurses and nursing assistants. We also urge the VA and this committee to listen to nurses in establishing realistic workloads.

S 2446

Extension of Respite Care

NOVA members who have had experience with respite programs have requested NOVA to strongly support the extension of the authority to provide this care to chronically ill veterans. Respite care has been an innovative and successful program and VA nurses believe it deserves continued support.

Thank you Mr. Chairman for this opportunity to testify before this committee. I will now be happy to answer any questions.

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Share the Light

Statement of:
Marie Manthey, R.N.,M.N.A.
President
Creative Nursing Management, Inc.
Before the:
Senate Committee on Veteran's Affairs
June 16, 1988

Mr. Chairman and members of the committee, I speak in support of all provisions of section 8, of S. 2462.

As a former nurse administrator who had responsibility for several clinical and support services, I am strongly in favor of that provision. Coordination of efforts resulting in significant cost savings and a great increase in operating efficiency can be expected as a result of this change.

Evening and night differential is a proven way to impact recruitment and has a powerful effect on reducing turnover by increasing schedule stability.

Collaboration between doctors and nurses is always beneficial to patient care and hospital operations, but usually falters without strong administrative support in the form of a physician - nurse collaborative practice committee.

The remainder of this submission consists of my views on the proposal to conduct a pilot program to evaluate various pay and personnel management practices. I am also submitting a description of a particular innovation called the Professional Practice Partnership system. This concept creates a new organizational relationship which results in alternative utilization of the skills and knowledge registered nurses use in providing patient care.

The **PROFESSIONAL PRACTICE PARTNERSHIP SYSTEM** is a real world adaptation to the current and coming nurse shortage that fits all delivery systems and provides critical relief to the issue of RN scarcity. It does so in a way that expands the RN's role without increasing stress and work pressure. Considered a nurse extender concept, the idea of 'bonded' partners provides a mechanism to extend an RN's expertise without reverting to mechanistic job descriptions and assignment patterns that have in the past dehumanized care and fragmented the RN's role.

HIGHLIGHTS OF MAJOR FEATURES

Senior partners are experienced staff nurses. Practice Partners

Marie Manthey, R.N. President

"Committed to excellence in nursing management, education, consultation and research."

may be recruited from a wide variety of educational and experience backgrounds. They may be placed in the health aide or the technician series of jobs within the VA system, depending on availability and the technical needs of the patient.

Partners regularly work together...the same shift, same schedule, etc. They manage a patient assignment with the Senior Partner determining what activities are most appropriate for the Practice Partner based on demonstrated knowledge and skills. The partnership in nursing as currently envisioned is analogous to the relationship between a physician and a physician's assistant.

Partnerships are formed through a careful selection process, involving the use of personality inventory assessments, and formation of a statement of agreement. The Senior Partner selects and directs the Practice Partner, a role normally fulfilled by a Nurse Manager.

Practice Partners may be trained to perform activities of a highly technical nature. Documentation of training and competence in the form of a credentialing process will be maintained by the Senior Partner in the Nursing Department.

Senior Partners should receive a substantial salary increase... we recommend in the range of $5 - 6,000/year.

As currently envisioned, RN's who become Senior Partners will receive additional training in the area of delegation, communication skills, and partnership maintenance.

The partnership system is a way to capitalize on the current reality of nursepower shortage by conserving the vital energy of our resources and to use this opportunity to strengthen and enhance the value of professional nursing practice.

HISTORICAL PERSPECTIVE

The organization of nursing services in acute care hospitals has evolved from a student-apprentice model, through an industrial work organization model, to the professional model seen in the delivery system called Primary Nursing. The origins of nursing delivery systems patterns organizational structure of the hospital.

With parentage in the military and religious systems of society (hospitals always advanced exponentially in wartime and were sustained as charitable work by religious), hospitals reflect traditional forms of hierarchical authoritarian control.
It is interesting to note that physicians in community and non-

governmental hospitals have maintained an arms length between their practice and hospital control. Although military and governmental hospitals integrate medical practice into their administrative control, medical practice in all other settings has traditionally been outside the purview/review of hospital administration. This relationship has been effective in maintaining the professional autonomy recognized as essential for the practice of medicine. The role development that resulted from this separation has effectively shaped the autonomy experienced by physician practicing in any setting.

In contrast, the achievement of any degree of autonomy in nursing practice is the result of creating a delivery system that restructured authority in the practice setting. Primary Nursing is based on the theory of decentralization which places authority for decision-making directly in the hands of the individual who has accepted responsibility for that function, in this case the Primary Nurse. Conceptually, then, Primary Nursing is the delivery system that allows for the development of professional practice.

Although the implementation of this concept has been fraught with problems, the success has been outstanding, and the benefit of professional nursing practice in improving health care has been well substantiated. In addition, successful implementation of this concept has effectively reduced turnover in nursing. As the concept was applied to the real world, it was often used in an attempt to solve other problems. As an argument to upgrade the level of practitioner in hospitals, nurse administrators used Primary Nursing as a means to justify an all RN staff. The concurrently rising acuity levels, caused by DRG'S and improved hospital utilization patterns, further justified these efforts. Thus for many, the concept of Primary Nursing became enmeshed in a staffing pattern requiring all RN's. For these, the issue of autonomy may not have been as important as achieving the right staffing pattern. At any rate, as the 'Current and Coming' nursing shortage is experienced, there is a dangerous tendency to move back into older organizational models incorporating the use of auxiliary personnel. These models (team and functional) are dangerous in that they are based on industrial rather than professional concepts of work organization.

These delivery systems were task-based models of work management that not only mitigate against professional autonomy, but that also result in recentralization of control and further loss of continuity and coordination of patient care.
An ancient truth about nursing care is that sick people benefit

from decisions made by one who knows them, and they benefit from being treated with consistency of approach. Thus, patients are better served when decisions are made by a nurse who also provides hands-on care. According to Drucker, knowledge-based work is to be differentiated from simple manual skill work. In a practice profession, knowledge-based work is an integration of academic learning and the knowledge acquired through the act of "hands-on" care. The amount of care a nurse needs to provide in order to learn what she needs to know to make the right care decisions cannot be mandated, but must rather be one of the autonomous decisions a professional practitioner makes.

Knowledge-based practice profession means the nurse integrates two sources of knowledge: that acquired in formal educational programs and that acquired in hands-on practice. The professional component of the description is exercised as the nurse decides the kind and amount of care a patient will receive.

THE PARTNERSHIP CONCEPT

Keeping this understanding of the nature of nursing in focus, a new concept of organizing and delivering nursing care is now being developed and tested. This new concept (really a natural evolution of Primary Nursing) involves the development of a "nurse extender"...an individual working as a technical assistant to an experienced RN.

The common component of this system is that each partner would function only in a relationship with a particular RN. As primary partners, there would have to be a personality match. The RN has final authority over the selection of her primary partner. Members of each primary partnership would work the same schedule. This paring would be an essential "must" of the program. These two would need to work together constantly, with the RN delegating duties as she decided her partner was ready to perform them.

The defining characteristic of this system is that each practice partner would work under the delegation of the Senior Partner, as her deputy, so to speak. The partner's performance is the legal responsibility of the Senior Partner. Thus, performance liability does not rest solely on the bureaucratic system (job descriptions, lower-level license, etc.), but is controlled by the RNs decision about which activities it is safe to delegate. In the beginning, the partner may be used as an aide...as confidence, training and experience grow, she could be used for more and more complex care. The partner is an extender of the nurse much as a physician's assistant is an extender of the physician. The nurse is fully responsible for care planning decisions.

SYSTEM IMPLEMENTATION

This concept is currently being developed and tested in a few sites. Called Partners-in Practice^{TM}, the process being used involves the use of a new data collection technique that provides information from 'nurse exemplars', top clinicians, the manager, most experienced staff nurses, nurse educators for the unit, etc.) responding in a group consensus format of an interview process that results in a determination of the amount of work on that unit that requires an RN's knowledge and skill vs. the amount that can be done by someone other than an RN working in a partnership model. The result of this technique is striking in that nurses who begin the process saying their unit requires an all RN staff (such as ICU settings), end up being comfortable in the understanding that a large percentage of the work they perform can be done by non-RN's. Thus, not only is the factual information acquired striking, but also that this analytical process results in significant attitude changes. A description of this process is available if desired.

Upon completion of the data collection, a report is prepared dealing with both the capacity impact of the partnership system, and with the administrative implications enumerated.

The next phase of the development is the selection and training of Senior Partners. A training program is being developed at this time.

Practice partner recruitment, selection and preparation is a multifaceted aspect of this concept. The degree of preparation (on-the-job or previously acquired) is dependent on the acuity of patient receiving care. Whether the training is on-the-job or previously acquired will be a function of several factors...market-availability being a major one. In communities with an excess of LPN's, individuals with that level of preparation may well be used in this role. In communities without individuals prepared as LPN's, EMT's, or former corpsman, etc. employing institutions may well decide to develop a hospital-based technician training program.

TRAINING IMPLICATIONS

One of the significant features of this concept is that practice partners may expand their level of technical performance through on-the-job training as delegated by the senior partner.

Protocols for performance documenting that training and demonstration of competence in a supervised setting is one of the many administrative implications of this system.

As experience with this role develops, career path tracks need to be established for practice partners to advance within the nursing profession using the education and experience acquired on the job. A tech should be able to move forward to an LPN program and/or on to becoming an Associate and Professional nurse if they wish.

As this concept is developed, several aspects require further study. These are both development issues and outcome issues.

> What techniques do nurses need to learn to be able to work with practice partners in a way the maximizes professional knowledge and ensures it is available when needed. What nagement skills does the Senior Partner need in order to manage the practice?
>
> What kind of protocols, on-the-job- training and credentialing policies need to be developed to support the concept and ensure competent care?
>
> What administration and personnel policies are required and how does the concept fit with normal unit operations.
>
> In what way do partnerships impact the Head Nurse role?
>
> How do various State Nurse Practice Acts impact practice partner role developments?
>
> What impact does the system have on patient outcomes, cost of care and nurse utilization, turnover and satisfaction?
>
> If the proposed salary plan is accepted practice, what effect will it have on keeping tenured nurses at the bedside?

STUDY SITES

These are but a few of the questions that need to be answered using a formal study/research disciplined approach. Two hospitals have expressed a strong interest in being test sites for this type of study and several hospitals are currently implementing the partnership system. A well controlled study in several VA hospitals could provide landmark data to strongly impact the future utilization of RN's in all hospital settings.

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STATEMENT TO BE PRESENTED TO VETERANS AFFAIRS COMMITTEE

U.S. SENATE HEARING - JUNE 16, 1988

Mr. Chairman:

I am Dr. Richard Magraw. On behalf of the National Association of VA Chiefs of Psychiatry (NAVACOP), an organization whose members serve in 153 of the Veterans Adminstration Medical Centers, I am here to speak in support of this bill. Currently, I am Chief of Psychiatry at the Minneapolis VA Medical Center, Professor at the University of Minnesota Medical School and immediate past-president of the Association.

First, Mr. Chairman, we want to say that your work on behalf of veterans is well known to us and greatly appreciated. We admire your record of 35 years service in Congress, and commend your work for a peaceful world. We particularly thank you, and your five co-sponsors, for introducing S2463, to establish research, educational and clinical centers for mental illness. It is our opinion that this bill will help VA services for the mentally ill match with those which are now provided veterans with other illnesses such as heart disease, infectious diseases, cancer, etc.

We have read the introductory statement you made when the MIRECC bill was presented on May 27, in which you outlined the need for such legislation. You noted that despite the fact that approximately 40% of VA patients suffer from these and related problems, educational funds, training stipends, research base and staff positions for Psychiatry were disproportionately low. We wish to endorse the points you made in that statement. Indeed, the fact that nearly 25% of all hospital beds in the country are occupied by persons suffering from schizophrenia might suggest that 25% of medical research funds would be allocated to this study instead of 1 or 2% as has been the case.

Dr. Ming Tsuang, who is Chairman of the Committee on Research for our association, will speak for us on the need for greatly expanded research in the field of mental illness. However, before Dr. Tsuang speaks, I wish to emphasize two things. Firstly, the importance to veteran patients of developing a research capacity that is integrally associated with educational and clinical services in the VA, as is envisioned in this bill proposing the establishment of MIRECC.

We need more knowledge to treat mental illness, and research now will surely bring more knowledge in future. However, our mentally ill patients will be better cared for today if that care is provided in an atmosphere of scientific investigation with the associated enthusiasm for clinical work which the spirit of inquiry engenders. In those circumstances, we can recruit a different caliber of physician to Psychiatry Services in the VA. Such a tide of scientific investigation spreads throughout the system and tends to "lift all the boats," as it were. This is part of the "academic connection" which, for the past 40 years, has well served veterans cared for in VA hospitals--although, as noted, the benefits for mentally ill veterans have been disproportionately low. To appreciate the importance of this academic connection to the mentally ill, we should bear in mind that while the Veterans Administration hospitals and clinics provide 15% of all the medical and surgical care which U.S. veterans receive, VA provides 50% of all the psychiatric care veterans receive.

Secondly, it should be emphasized that we are in a time when brain sciences research is coming into its own. New knowledge is bursting out all around us like popcorn in a pan. Part of our effort needs to go toward fostering the application of the new information to the direct care of patients. The projects proposed in this bill directly serve that need.

I turn now to Dr. Ming Tsuang. He is Chief of Psychiatry Services at the VA Medical Center at Brockton/West Roxbury, Massachusets, Professor of Psychiatry, Harvard Medical School, Director of Psychiatric Epidemiology, Harvard Medical School and School of Public Health, Harvard University. As noted, Dr. Tsuang serves as Chairman of the Committee on Research of the Association of Psychiatry Chiefs. He is one of the most distinguished scientists in the Veterans Administration. His fellow Chiefs of Psychiatry feel fortunate to have him among their number and to speak for us in this matter.

TESTIMONY ON S. 2463

Prepared Statement to the United States Senate
Committee on Veterans' Affairs
by
Ming T. Tsuang, M.D., Ph.D.,
Chairman, Research Committee, National Association of
VA Chiefs of Psychiatry;
Professor of Psychiatry,
Harvard Medical School

June 16, 1988

Mr. Chairman:

I have the honor of representing today the National Association of VA Chiefs of Psychiatry (NAVACOP), a truly national organization dedicated to improving and promoting the mental health care services available to our nation's veterans. On behalf of the members of the Association, I would like to express my gratitude for the opportunity to testify today in support of proposed legislation S. 2463.

In our view, S. 2463 deserves support because it directly addresses critical needs of the VA psychiatry program in the areas of clinical services and academic activities. Our ability to provide adequate services in these areas is currently being eroded because of a longstanding pattern of low priority and underfunding; a pattern that if allowed to continue has the very real potential of permanently damaging the VA's ability to meet the mental health care needs of our veterans.

To put my comments in perspective, it is helpful to review the status of psychiatry services within the VA. There are a number of statistics pointing to the substantial mental health care needs of veterans, but none is more direct than the actual number of psychiatric patients: in FY87, the average daily inpatient census was about 55,000, of which 17,000 (31%) were psychiatric patients. In addition, about half of Intermediate Care patients suffered from psychiatric conditions. On the whole, psychiatric problems accounted for about 40% of bed days in the VA. It is worth remembering that a large number of these patients suffer from debilitating chronic conditions which are only partially understood and for which satisfactory treatments are still not available. Within the VA, Psychiatry treats more Service-Connected patients than Medicine and Surgery (DM&S), and actually has a larger "market share" of the veteran population as a whole than DM&S. In other words, a veteran with a psychiatric illness is more likely to seek VA assistance than one with a medical illness.

Clearly then, the VA has a mandate to meet the serious mental health care needs of a very large number of America's veterans. But is it in fact doing so? Psychiatric services within the VA have been traditionally understaffed and underfunded, and there is no immediate prospect of substantial improvement. NAVACOP has found that many VA psychiatrist positions are vacant and that recruiting is getting more difficult. This points out the present clinical need which unfortunately is compounded because of the absolute necessity of recruiting and retaining psychiatrists who are not only skilled clinicians, but also skilled and creative researchers and educators. The reason is the same one that guides policy in Medicine and Surgery: that today's accepted standards of mental health care are constantly being overtaken by major advances and even revolutions in our understanding of these conditions. Extraordinarily rapid developments have taken place in neuroscience and cognitive psychology, and in molecular biology, problems relevant to psychiatry are being addressed. More traditional research areas of clinical phenomenology and diagnostics, epidemiology, psychoparmacology and even psychotherapy and psychosocial rehabilitation outcome research have attained a maturity comparable to that seen in clinical medicine. Consequently, even adequate mental health care will rapidly become substandard care unless VA clinicians participate in and directly benefit from the very active research and educational activities that are occurring at present in the field of mental health.

What then of the VA's ability to attract and retain mental health professionals with strong research and educational interests and skills? Unfortunately, the VA has fallen behind in just about every measure relevant to young, research-oriented psychiatrists: salaries have lagged behind even State hospital renumerations; there is less resident support; there is underfunding of psychiatric research; and there is unremitting increase in workload unfavorably and unfairly measured by a DRG system that has no measurable validity for psychiatric conditions.

To illustrate the degree of underfunding of psychiatry training within the VA, I would refer again to the statistic from FY87 that approximately 40% of VA bed days were for psychiatric patients. In contrast, less than 10% of the residency positions within the VA are allocated to Psychiatry. Consequently, while patient-to-resident ratios average 6:1 in Medicine, they average 16:1 in Psychiatry. The same pattern of underfunding is evident in psychiatric research, where from 7% to 9% of approved Merit Review research grant applications are funded for psychiatric and behavioral research, and in dollar amounts cover less than 10% of the VA's direct research budget. Between 1980 and 1984, only 7 of 392 funded career development awards went to psychiatrists, and only 26% of the psychiatrist applicants were funded, compared to 42% of the total applicants within the VA who received funding.

In light of these clinical and academic (i.e., research and training) problems, there is a pressing need for major changes in

VA priorities and funding policies on the national scale. Although the proposed mental illness research, education and clinical centers (MIRECCs) do not address the magnitude of the problems confronting VA psychiatry, they will go part way toward finding solutions and can be expected to have a positive influence far beyond their proportionate cost, in view of their high visibility and their potential for attracting "critical masses" of scientists and clinicians to work intensively on the mental health care issues confronting the VA. The MIRECCs should provide a productive structure within which to delineate some of these issues, propose clinically viable solutions, and test those solutions on a small but reasonable scale. It is critical for the success of this enterprise that the MIRECCs help to promote the close cooperative ties that already exist between VA medical centers and major universities, and we are satisfied that the provisions of S. 2463 will adequately address these needs.

In our view, it is also critical for the success of the proposed program that the MIRECCs be fully competitive with regard to scientific and clinical merit for the purpose of allocating resources. As I have pointed out, the problems of VA Psychiatry exist on a national scale, and they can best be addressed by supporting special efforts like the MIRECCs that specifically allocate limited available resources to the groups most likely to make major contributions that will eventually benefit the entire VA mental health care system. Also, our position is that ongoing review of the MIRECCs in the form of regular five year site visits is the optimal way of achieving a balance between encouragement of scientific and clinical innovation, and the need for oversight and accountability.

In summary, the National Association of VA Chiefs of Psychiatry is fully supportive of the legislation proposed in S. 2463 to establish five centers for mental illness research, education, and clinical activities. We are convinced that it is only by promoting creativity and innovation in these closely interrelated areas that the VA will be able to perform its mission and truly meet the pressing mental health care needs of our nation's veterans.

Thank you for your careful consideration of this statement.

American Psychiatric Association
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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

ON

S. 2463, ESTABLISHING

MENTAL ILLNESS RESEARCH, EDUCATION, AND
CLINICAL CENTERS OF EXCELLENCE

PRESENTED BY

CHARLES O'BRIEN, M.D., PH.D.

CHIEF OF PSYCHIATRY SERVICES
PHILADELPHIA VA MEDICAL CENTER

VICE CHAIRMAN, DEPARTMENT OF PSYCHIATRY
UNIVERSITY OF PENNSYLVANIA

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE

ON

JUNE 16, 1988

Mr. Chairman, Members of the Subcommittee:

I am Charles P. O'Brien, M.D., Ph.D., Chief of Psychiatry Services at the Philadelphia VA Medical Center and Vice Chairman of the Department of Psychiatry, University of Pennsylvania. I appear before you today on behalf of the American Psychiatric Association, a medical specialty society representing over 34,000 psychiatrists nationwide.

The APA appreciates the opportunity to appear before you today to testify in support of S. 2463, legislation introduced by Senator Cranston which would require that the Veterans' Administration establish five mental illness research, education, and clinical centers (MIRECC's). It is no secret that the funding level for psychiatric research in the VA is vastly disproportionate to the utilization of psychiatric services, and that the resulting deficiency in resources for psychiatry in the VA only serves to diminish the quality of care provided a population in dire need of the services our profession is equipped to provide. Senator Cranston's willingness to address and alleviate this problem through the introduction of S. 2463 indicates that these previously ignored critical issues - quality of care and the importance of research in the VA - have reached crisis proportions which demand your immediate attention and action.

The question is obvious: Do VA psychiatrists receive VA research funding commensurate with either the number of psychiatrists or the need for psychiatric research within the VA system?

With a history of uneven funding over its 30-year Congressionally mandated lifetime, and a health care system which has seen a multiplicity of changing needs and directions, the Medical Research Service (MRS) has continued to encourage biological and behavioral research and training within an Agency for which medical research has not been the first priority.

At an April 1985 meeting of the Special Purpose Committee to evaluate the mental health and behavioral sciences research program of the VA and its merit review evaluation process, questions regarding the commitment to mental health and behavioral science research crystallized around a number of topics. The psychiatrists at that meeting from the academic/scientific community and those working within the VA research system, spoke about the need for greater financial support for mental health research and for equally greater commitment in the area of research career development. While they granted that the track record over time has improved substantially, the key argument was made that proportionally, psychiatric research falls far short of the "burden of psychiatric illness among veterans." Further argument was made by Seymour Kety, M.D., Chair of the Committee and Louis Jolyon West, M.D., a member of the group, in a letter summarizing the findings of the Committee that "there are many well qualified psychiatric and behavioral science investigators who apply, or could apply, for research support in the VA but are not funded."

In part, some of this difficulty may be the result of historically insufficient funding for both training and staff positions within the VA for those in psychiatry. While improving over time, the absolute numbers of psychiatrists -- clinicians and researchers alike -- remains disproportionately low. With the ever-increasing number of patients with psychiatric illness, few staff or house staff psychiatrists are able to add the conduct of research to their clinical responsibilities.

This inability to free up adequate research time given the heavy clinical demand for psychiatric services within the VA system has had the effect of lowering the absolute number of proposals received from psychiatrists by the VA. MRS Director Richard Greene, M.D., Ph.D., points out that in recent years, the proportion of applications for Career Development positions by research psychiatrists has been substantially lower than that for other medical investigators. With a highly competitive program such as the Career Development Program (CDP), the number of approvals, relative to other specialties, therefore is lower. There may be as few as three to four applications for this particular program in psychiatry in any given round.

Kety and West suggest in their report that one of the reasons there are so few applications from psychiatrists to the CDP is that "many potential applicants are discouraged in advance.... From the Fall of 1982 through the Spring of 1984, 192 career development award positions were funded; only 2 went to psychiatrists."

The data supporting claims that support for psychiatric patients and psychiatric research is underfunded is overwhelming. For the first six months of FY '87, the average daily number of occupied beds was 55,000. Of that number, 17,000 beds (approximately 40%) were occupied by psychiatric patients. During the same time period there were approximately 4 million ambulatory visits to mental health services, representing 22% of the 18.5 million total visits to the VA. The data confirms that, obviously, psychiatric resources are being heavily utilized by veterans. Apparently what has not been evident is the disproportionate share of dollars directed to psychiatry.

It is alarming that a mere 17% of research support monies were directed towards psychiatry in the first half of FY '87. In addition, the dollar amount for behavioral research represents less than 10% of the total budget. During the period between 1983 and 1986, 74% of all the grants received at the VA were approved with 55% actually receiving funding. However, only 12% of the grants approved were for behavioral science research and, of that figure, only 42% were approved and funded. As stated previously, the clinical demands placed on VA psychiatrists' time severely hampers their ability to conduct scientific research, yet less than 10% of residency positions are allocated to psychiatry and the educational support budget contained only a 16% share for psychiatry.

Research can and will provide us insight to arrive at more effective treatments and services for patients and their families. We believe that Senator Cranston's bill would go a long way towards rectifying the discrimination exemplified towards research and treatment of mental illness. The legislation's creation of research centers which focus on the biomedical and psychosocial aspects of mental illness, and focus on the examination of the models of providing service, will enable researchers to achieve a greater understanding of the relationship between the behavioral manifestations of the brain and body.

Each of the three areas of research emphases contained in the proposed MIRECC models will offer much in the continuing effort to eliminate the undeniable toll on human life and productivity, affecting not only those millions of Americans suffering from mental illness, but also their families and associates and, indeed, the nation's health and economy as a whole.

Research is on the threshold of a new understanding of the bases of major mental illnesses. For example, research on schizophrenia -- a disease twice as common as Alzheimer's disease -- has encompassed a broad spectrum of sciences -- from the most molecular of the biological sciences to the broadest of the behavioral. Clues to etiology and treatment are being sought in the biochemistry of nerve cells as well as in the psychology of human personality; in methods for visualizing the brain as well as in techniques for assessing intellectual functions; in the assessment of drug therapies as well as in the evaluation of vocational rehabilitation programs. Treatment costs for the nation for schizophrenia exceed 7$ billion annually. Much must be done to alleviate the suffering from schizophrenia. The creation of this legislation is certainly a step in the right direction.

In the area of Alzheimer's disease you should know that as many 2.5 million Americans by the year 2000 will be diagnosed as suffering from this devastating disease. Among the Veteran population alone the anticipated prevalence of Alzheimer's disease and other dementias will rise from over 200,000 veterans to 500,000 veterans. As a nation we spend $40 to $50 billion a year to care for elderly dementia victims, yet in FY '87 we spent less than $80 million on research on all forms of dementia. However, through research we are on the brink of major scientific breakthroughs. Research has led us to the identification and localization of a neurochemical deficit in the brains of patients with Alzheimer's disease. Researchers have identified both a protein and a blood platelet abnormality. Studies such as these may well lead to the development of a positive diagnostic marker for the disease.

In the area of addictive disorders, there is a well publicized national crisis. Substance abuse is a major problem for veterans and the VA delivers a great deal of treatment in this area. However, very little research on addiction is funded by the VA. Research on addiction funded by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has made significant progress. The VA should be conducting studies of new treatments for addictive disorders in order to improve the care for veterans in this important area.

I could list other promising findings in the areas of manic-depression, other affective and anxiety disorders, childhood and adolescent disorders and disorders of the elderly, if time could permit. Suffice it to say that the nation is poised for breakthroughs in the 1990s that will generate clinical successes during the 21st century. The most important benefit will be the improved quality of life for patients and their families.

In addition to the psychosocial and biomedical aspects of research, it is essential that the nation also support a strong program of health services research. For your information, this field focuses on increasing knowledge on the production, organization, distribution, and impact of health care services. As a closed health care system, the Veterans' Administration serves as the perfect research model.

The VA already has a program of geriatric centers (GRECCs) which has stimulated progress in disorders of the aging population. The proposed MIRECCs can draw on this experience in setting up centers of excellence which would increase the volume of research in the mental health area while not sacrificing quality.

Support for Research Training, an important adjunct to basic research support, is critical in order to attract talented professionals to research careers, specifically in evolving specialty areas such as schizophrenia and Alzheimer's disease. Consider this the "infrastructure" of research - the expert manpower needed to promote scientific research of the scale and scope necessary to meet the challenges of mental illness. Support for the development of talented psychiatric researchers clearly has been disproportionately small compared to the needs of the field. We have argued this repeatedly before the House and Senate Appropriations Committees in our advocacy for research supported by the National Institute of Mental Health (NIMH) and Congress has begun to recognize the need to build an expert cadre of research manpower upon whom the sucess of the research mission depends. We emphasize to you today that the present supply of research personnel is not nearly equal to the task of carrying out the research initiatives described in my testimony. The inability to recruit and retain psychiatrists in the VA has reached a critical stage where, alarmingly, 21 facilities report vacant slots for psychiatry for more than 1 year and a total vacancy rate of 146 psychiatrist positions.

Mr. Chairman the science of understanding mental illness has helped to eliminate the traditional stigma attached to the disorders I have outlined. We have discovered that there are biological bases to most of the major debilitating disorders, thereby reducing the historic stigma heretofore felt to be the result of environment, social factors, etc. This is the message that our citizen allies continue to articulate with us before Congress. In fact research support is a leading issue of the families of the seriously mentally ill. Establishing Mental Illness Research, Education and Clinical Centers of Excellence provides an opportunity for the Veterans' Administration, and the research community together, to participate in a state-of-the-art innovative process. It is a modest investment to make when one considers the monumental possibilities for improving care and treatment of veterans. It is staggering to consider the potential contribution that VA has to offer the research community as a whole and the mentally ill population at large.

Thank you for this opportunity to present our views in support of S. 2463.

TESTIMONY OF

DR. PATRICK BOUDEWYNS
Chief of Psychology Service
VA Medical Center, Augusta, Georgia

on behalf of
THE AMERICAN PSYCHOLOGICAL ASSOCIATION

before the
UNITED STATES SENATE VETERANS' AFFAIRS COMMITTEE

June 16, 1988

Good Morning. Mr. Chairman, I am Patrick A. Boudewyns, Chief of the Psychology Service at the VA Medical Center in Augusta, Georgia. I am also a member of the Chief Medical Director's Special Committee on Post Traumatic Stress Disorder, and principle investigator of the Research Service of the VA.

I am testifying, today, on behalf of the 90,000 members of the American Psychological Association (APA). APA is the major scientific and professional society representing psychology in the United States. Many of our members are researchers and practitioners in Veterans Administration (VA) centers and hospitals across the country. According to 1987 data, there are 1587 psychologists who are trained as scientists/practitioners employed full-time in the VA, and 175 part-time psychology scientists/practitioners.

Thank you for inviting us to testify regarding S. 2463, a bill that authorizes the establishment of five mental illness research, education, and clinical centers within the VA. These centers would be an important addition to current VA research programs that are already recognized for their excellence. I was encouraged to note in Senator Cranston's statement, upon introduction of this legislation, that the stated mission of these centers would be to coordinate research, the training of health care personnel, and the development of improved models of clinical services for eligible veterans. VA psychologists have long been active and are leaders in research design and methodology in the VA and throughout other health systems, and in academic and research centers throughout the world. The coupling of research and clinical services is certainly a winning combination. They would truly be "Centers of Excellence".

Psychological research in the VA had a small beginning when a clinical psychology section was organized within Psychiatry and Neurology Services in 1946. As time went on, many hospitals hired full-time research psychologists. However, less attention was paid to the clinical implications of research at that time. It was a period where money was not the issue, but probably neither was efficiency. Novice researchers had the opportunity to spend several years developing ideas with little oversight of their progress, or the merit of their research because local monies were available for start-up grants.

VA funding of research programs in the 1980's, while limited, is now competitively based and subject to review by the various program entities. The major research programs in existence today include - the Research Advisory Group (RAG) program, the Career Development Program, Research Career Scientist Program, and the Medical Research Program. Other more specialized programs also exist.

The limitations on research began in the 1970's when money for research started to dry up. For psychologists this meant that, starting around 1977, new researchers were unable to obtain career positions as research psychologists due to the reduction. Even psychologists with career positions were teetering on the edge - measuring their security in terms of ongoing funded research programs. This phenomenon, for the most part, continues today. Over 80% of all researchers in the VA have their salaries paid through clinical sources.

There are other features of the VA system in addition to dwindling research dollars that deter development and implementation of appropriate levels of research in mental health and behavioral sciences. For example, Civil Service and VA personnel regulations that are applied to psychologists but not applied to physicians hamper psychologists in their quest for research funds. The difference is illustrated in statute (Title 5 vs. Title 38). Psychologists cannot as easily move from clinical practice to research activities and back like their physician colleagues.

Another deterrent to psychologists' participation in VA research is illustrated in certain practices of the Career Development Committee. This particular committee with its tiered system of research positions will fund research by psychplogists. However, as Senator Cranston pointed out in his floor statement, the Committee includes only one psychiatrist and *no* psychologists among its members. While figures on the number of psychologists who receive VA career development awards are unavailable, if only 26 percent of psychiatrists who made application are funded, it is likely that psychologists comprise a smaller percentage. In theory, the ascending levels in the Career Development program that offer increased compensation along with more independence can encourage quality scientific work. In reality, however, psychologists seldom move from one level to the next because of the aforementioned personnel regulations.

Other research programs exist in the VA, but no centralized mechanism exits to standardize procedures. Each program has its own director and own "way of doing things". This presents problems for the researcher who is attempting to work within the system. Efficiency is compromised when an individual must tailor one application or proposal numerous ways to suit each and every program.

I believe the Kety Committee, whose recommendations provided the impetus to the introduction of S. 2463, is absolutely correct when they suggest that in order to deal with the mental health of Veterans we must offer proportional monetary support to research as compared to the documented need. VA psychologists agree that research is an investment in the present and future health of our Veterans, as well as the general population as a whole. Without a doubt, it improves care. In addition, stable proportional funding is more efficient for researchers. Also, not to skirt the issue of budgetary considerations, research funding is cost effective. A relatively small investment, currently a fraction of total VA health costs, can serve to facilitate the development and utilization of behavioral techniques that will, in the long run, save money in non-mental health care utilization while generally improving the quality of health care delivered in the VA.

I am particularly pleased with the proposal contained in S. 2463 on a number of counts, many of which will address some of the problems I have identified earlier for you in my testimony. However, I would like to add that the system proposed in the legislation has been modeled after a very successful program currently in place in the VA known as the Geriatric Research, Education, and Clinical Centers (GRECC's) program. This program is extremely effective for several reasons, the most critical of which, I believe, is its multidisciplinary approach to program administration, funding, research, and program implementation. Partnerships with graduate schools of psychology, medical schools, nursing, social work, and other allied groups will allow for maximum exposure and assimilation of the broad range and different types of expertise within the various disciplines in mental health. Ultimately, this approach will improve mental health research and care in the VA.

I commend Senator Cranston, the original cosponsors of S. 2463 - Senators Murkowski, Matsunaga, DeConcini, Rockefeller, and Graham - and the Veterans' Affairs Committee for their concern with the mental health needs of Veterans. Illness, whether it be mental or physical, benefits immeasurably from research, education and the application of both to patient care. Depression, AIDS, post-traumatic stress syndrome, alcoholism and substance abuse, and a host of other disorders are serious national problems that disproportionately affect veterans, and present a challenge to VA researchers and health care practitioners. We must not hinder their work by devoting too few resources to their cause.

On behalf of the APA, I thank the Committee for the outstanding work that you're doing with regard to the health needs, particularly the mental health needs, of Veterans. Thank you for the opportunity to testify on this outstanding piece of legislation, and I look forward to seeing Mental illness research, education and clinical centers come to fruition in the near future. I'd be glad to answer any questions.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

SAMUEL J. WALSH, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

PHILIP R. WILKERSON, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

on

VOCATIONAL REHABILITATION PROGRAM OVERSIGHT
and
OTHER VA LEGISLATIVE INITIATIVES

JUNE 16, 1988

STATEMENT OF PHILIP R. WILKERSON, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
JUNE 16, 1988

Mr. Chairman and Members of the Committee:

We appreciate this opportunity to offer The American Legion's views on the several proposals relating to veterans health care and other benefits and services administered by the VA that are under consideration during today's hearing.

S. 2462 - Section 2 of this measure would extend entitlement for readjustment counseling to veterans who have served in hostilities after May 7, 1975, and to World War II and Korean conflict veterans, with particular emphasis on furnishing counseling to those who served in combat.

The American Legion strongly supports the extension of eligibility for readjustment counseling to veterans of prior wars, or to those individuals in service during periods of time and in specific locations in which U.S. Armed Forces were engaged in combat. There is no doubt that the Marines in Beirut, and many of the Army, Navy, Air Force and Marine Corps personnel involved in the invasion of Granada were faced with life-threatening incidents - the precursor of PTSD. Unlike the situation that existed when veterans were returning from Vietnam, much more is now known about the causes, effects, diagnosis and treatment of PTSD. We would hope that the latest group of American troops involved in combat were provided a period of desensitization or decompression, much like that provided the American hostages upon their release from Iran. A program of this nature should alleviate future problems for many of these military personnel. Likewise, we are aware that there are veterans of WW II and the Korean War who will benefit from the enactment of this provision.

Section 3 of this proposal would authorize to be appropriated for each fiscal year during the period beginning on October 1, 1989, and ending on September 30, 1992, the sum of $500,000, to be used by the Administrator of Veterans Affairs for making grants to the Veterans Memorial Medical Center in Manila.

We note that both the authority to provide for payments for hospital and medical care, and the authority for the $500,000 annual appropriations to be used for grants, expires on September 30, 1989. Extension of these authorizations for 3 years, through September 30, 1992, is highly supported by The American Legion.

Section 4 of this measure would authorize the Administrator to appoint to civil service positions, without regard to the civil service register process described in subchapter I of Chapter 33 of title 5, newly graduated, qualified health care professionals who held a VA appointment while completing a clinical education process. It is noted that physicians and dentists are not included in this authorization.

Mr. Chairman, The American Legion recognizes the benefits associated with this proposal, especially in terms of enabling VA to offer employment in a more expeditious manner. In fact, VA would be able to secure career commitments even in advance of graduation. In addition, substantial savings should result as recruitment and orientation costs are reduced as a result of this proposed legislation. The American Legion notes for the record that this measure specifically preserves the current statutory preference for hiring veterans.

Section 5 of this proposal would amend section 4107(g)(4) of title 38. This amendment would require the Director of the Office of Personnel Management to concur with, or disapprove VA proposals for special rate authorization for title 5 employees employed at VA health-care facilities, within 45 days, as opposed to the current 90 day requirement. The American Legion would support this proposal.

Section 6 involves amendments relating to the Chief Medical Director's authority with respect to disciplinary actions on certain title 38 health-care employees.

Additionally, this section would create, in title 38, a grievance resolution process that parallels that available to title 5 employees. The American Legion has no position on this legislation, basically because it involves internal personnel matters relating to the VA.

Section 7 proposes to expand the categories of facilities with which the VA could enter into sharing agreements so as to encompass any health-care facility.

The American Legion does not see any problems with the provisions included within this measure, and therefore we do not object to this proposal. We note that this measure would also require the money be returned to the facility involved in the sharing, and we support that aspect of the provision.

Section 8 of S. 2462 would authorize the appropriation of $5 million for each of Fiscal Years 1989 and 1990, and $6 million for each of Fiscal Years 1991 and 1992 for the purposes described in subchapter III of Chapter 82 of title 38, which relates to assisting institutions affiliated with the VA to increase the production of health-care personnel. In addition, this section would direct the Administrator, when establishing new careers, interdisciplinary approaches and career advancement opportunities, to collaborate with individuals in the professions which carry out the functions for which those in the new careers would be responsible. The Administrator would be required to provide annual reports to the appropriate Congressional Committees on the implementation and progress of the program.

The American Legion, cognizant of the nationwide health professional shortage, and the problems VA is having in recruiting and retaining certain health-care professionals, supports this proposal. The funding proposals included in this measure should serve to increase enrollments of health personnel in schools and colleges, many of which are currently experiencing a decline in this regard. As noted in the explanatory language of this proposal, a case in point would be nursing school enrollments. It was related that the number of first-time, fulltime, 4 year college freshmen indicating a desire to enter nursing had dropped from 42,000 in 1983 to 19,800 in 1986.

Section 9 would require the Chief Medical Director to conduct pilot programs at not less than five VA medical facilities during calendar years 1989, 1990 and 1991. These pilot programs will be conducted to determine the desirability of implementing various pay and management practices relating to the recruitment and retention of registered nurses and other health-care professionals.

Specific provisions contained within this section will authorize the CMD to, at not less than three sites, expand the administrative and supervisory responsibilities of the Chief of Nursing Service to include responsibility for support services and clinical departments other than nursing. Furthermore, the CMD shall, at not less than one site, establish a collaborative-practice committee involving physicians, nurses, and, as appropriate, other direct health-care personnel. Other provisions of this proposed pilot program would authorize the CMD, at not less than one site, to significantly increase the pay differential for evening and night service. Finally, at not less than three sites, the CMD shall implement new alternatives for utilizing the skills and knowledge of registered nurses in the furnishing of direct patient care.

Mr. Chairman, these pilot programs are certainly designed to address three major areas of concern registered nurses in the VA system continuously express to our National Field Representatives during site visits to health-care facilities. Specifically, many nurses are concerned about their working relationships, or lack thereof, with those physicians with whom they work on a daily basis. Lack of respect and recognition of their contributions are commonly heard complaints. Establishment of collaborative-practice committees will somewhat address this issue by ultimately fostering a closer working relationship between physicians, nurses and other health-care workers.

Two other commonly heard concerns expressed by nursing personnel in the field involve their having to perform nonnursing care duties, and inadequate monetary recognition for weekend duty, evening, and night shifts. Information gathered from these pilot programs will address these issues as well, and should prove to be extremely beneficial to the VA system in terms of further defining and hopefully improving their overall recruitment and retention problems. We note specific requirements regarding the submission of various reports from the CMD regarding these pilot programs, and concur with those requirements.

Section 10 of this measure would mandate the submission by the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder of three reports. The first report, due by April 1, 1989, would set forth the Committee's evaluation of the results of the study mandated by PL 98-160 on the prevalence and incidence of PTSD among Vietnam veterans. The second and third reports required, due February 1, 1990 and 1991, respectively, would set forth information which updates prior reviews of the overall effort of the VA to meet the needs of veterans with PTSD.

The American Legion strongly supports this measure.

The Special Committee is carrying out a number of important responsibilities relating to the Veterans Administration's ability to diagnose and treat PTSD. One of the reasons that this Committee is effective is that it does report to Congress on its findings and recommendations. The legislation that established the Special Committee and sets forth its responsibilities, only mandated the presentation of annual reports to Congress through 1989. Therefore, as previously stated, we fully support this provision.

S. 2463 would authorize the Veterans Administration to establish five mental illness research, education, and clinical centers (MIRECCs). These centers would be modeled after the VA's geriatric research, education & clinical centers (GRECC) program, as outlined in section 4101(f) of title 38. This proposal would authorize the appropriation of $3.125 million in Fiscal Year 1989, and $6.25 million each for the next three years, to support these centers.

As this Committee knows, GRECCs are designed to enhance the system's capability in geriatrics by conducting integrated research, education and clinical care. The purpose of the GRECCs is to develop new knowledge regarding aging and geriatrics, and to disseminate that knowledge through education and training of health care professionals and students. Finally, the 10 GRECCs currently operational are charged with developing and evaluating alternative models of geriatric care.

The American Legion would agree with the need for similar centers to improve and expand the capability of VA health-care facilities to respond to the needs of veterans suffering from mental illness.

However, as this Committee also knows, implementation of the GRECCs has been a slow process for VA, due to inadequate resources. At present, 10 centers are operational, with two additional centers reportedly in the planning stages. Public Law 96-166, "Veterans Administration Health-Care Amendments of 1985", increased from 15 to 25 the maximum number of facilities the VA Administrator may designate. Therefore, although 15 additional centers are authorized for activation, the VA is unable to fund such activations in a timely manner. The American Legion, an ardent supporter of the GRECC concept, is concerned that similar difficulties may eventually be experienced by MIRECCs, and we caution that the long-term benefits of this proposal would be directly linked with continuous adequate funding.

S.2207 would amend section 614 of title 38, to authorize the Administrator of Veterans Affairs to provide simians and dogs specially trained as assistive animals to any veterans, who by reason of quadriplegia, are entitled to disability compensation under laws administered by the Veterans Administration.

Mr. Chairman, The American Legion supports this proposal because we feel that research has proven this assistance to be beneficial to quadriplegic patients and therefore, it is inconceivable that an available resource would not be utilized to help the approximately 2300 service-connected quadriplegics currently on the VA's rolls.

The VA has provided significant funds for researching the training of simians to assist severely disabled individuals in their homes. The results of this investment should be afforded quadriplegic veterans, thereby improving their quality of life, self-confidence, independence, and socialization.

S. 2446 would amend title 38, USC, to extend to September 30, 1990, the VA's authority to furnish respite care to certain chronically ill veterans, and extend to February 1, 1990, the date by which the Administrator is to submit a report on the evaluation of such a program to the House and Senate Veterans' Affairs Committees.

Mr. Chairman, section 201 of Public Law 99-576, authorized the VA to furnish respite care services until September 30, 1989 to eligible veterans. Furthermore, under this provision, the Administrator is required to conduct an evaluation of the health efficacy and cost-effectiveness of furnishing respite care and submit a report to the Senate and House Committees on Veterans' Affairs on the results of this evaluation.

However, VA Central Office did not provide field stations with admission guidelines and other instructions concerning this program until the end of 1987. Indications are that a large number of VA medical centers are anxious to become involved in this program, and highly support the concept of "care for the caretaker."

This allows the provision of scheduled relief for the caretaker, ultimately allowing veterans with serious illnesses to remain in their homes, and avoids the high costs and other negative factors of institutionalization.

Mr. Chairman, The American Legion has over the past several years consistently supported the theory of maintaining the veteran-patient in the community as much as, and for as long as possible. In our analysis of the VA report entitled "Caring For The Older Veteran" it is pointed out that in looking to the future from the Legion's standpoint, we will have to realize the fact that many more veterans will be receiving health-care in community settings under the Veterans Administration's guidance. Cooperative efforts with community programs are already underway to a limited degree. It is important that these efforts be expanded, and that liaisons with community resources that share VA's interest in the aging are maintained. In addition, it must be emphasized that alternative care programs featuring noninstitutional care settings must be aggressively pursued to help contain costs.

On a number of occasions during hearings before this Committee, we have stated that it is our intent to encourage both Congress and VA to foster the development and implementation of all of the innovative techniques that can be used to both make the system more cost-effective, and able to care for the largest number of patients.

The American Legion therefore supports this measure which will provide VA adequate time to evaluate the benefits and cost-effectiveness of VA respite care. Based upon preliminary statistics, the vast majority of the beneficiaries of this program will be aging veterans. Statistics show that the average age of the veterans admitted to this program thus far is 68 years. More importantly, approximately one-fourth of these veterans are over 75 years old. Furthermore, in over half of these cases, the veteran's informal support system consists of only one person. By caring for the caregiver, these elderly and frail veterans will be provided the opportunity to remain within their own homes in the care of their loved ones, which is not only more cost-effective, but is also better for the patient's overall health.

S. 2293 is a bill to amend title 38, USC, sections 5002(d) and 5004(a)(4), to raise the Veterans Administration's minor construction cost limitations from $2 million to $3 million.

The American Legion supports this measure as we note that the $2 million level has been in effect since 1981. Since that time, project costs have significantly increased due to inflation and other factors. We believe this change could improve the method by which minor construction projects are obligated, by lessening the degree of preliminary oversight and by reaching contractual awards more readily.

Mr. Chairman, we are pleased to offer comment on the current status of the VA's program of vocational rehabilitation for service-connected disabled veterans, under Chapter 31 of title 38, United States Code.

Prior to 1980 and the enactment of Public Law 96-466, the agency's efforts to rehabilitate veterans was rather narrowly focused on providing education and training to the point where they were determined to be employable. Employability, however, was not synonymous with actual employment. As a result, disabled veterans, in the main, were left substantially on their own to secure suitable employment following the completion of their VA vocational rehabilitation program. The lack of comprehensive and interrelated rehabilitative services and job development and placement assistance were among the major shortcomings of the program up to that time.

In 1980 Congress sought to address these and other issues affecting disabled veterans through a broad restructuring and expansion of the program of training, education, and employment-related services to provide a unified program of vocational training which encompassed pre-training and post-training services and assistance, including the availability of independent living services to veterans with severe disabilities. It also provided for improved coordination with other Federal agencies and their programs of employment assistance. The American Legion supported this legislation and welcomed its enactment as a demonstration of the continuing commitment of the Federal Government to assist service-connected disabled veterans in overcoming their handicaps and regaining their rightful place in the labor market, as well as providing an important means by which to improve their lives.

Public Law 96-466 represented an historic revision of the program, in terms of goals established for the agency and for individual veterans, the nature and scope of the services authorized, and improved management and administrative procedures. The mission thus became one of providing all services and assistance necessary to enable veterans with service-connected disabilities to achieve maximum independence in daily living and, to the extent feasible, become employable and obtain and maintain suitable employment. Applicants found to need assistance because of an employment handicap based on a service-connected disability are evaluated to determine if they need services to enable them to be more independent in the activities of daily living, or education or training to provide them with job skills, job placement or other types of employment assistance. Disabled veterans who do not have appropriate job skills are assisted in developing an education and training plan which will provide them an opportunity to learn needed skills. Those veterans who complete programs of education and training, and who are determined to be ready for a job, are to be provided employment services to assist them in finding employment which is compatible with their aptitudes, interests, abilities, and disability limitations, as well as follow-up services once employment has been secured.

This legislation included the additional responsibility of providing comprehensive counseling and assessment services, on request, to veterans, servicepersons, and qualified dependents who are eligible for VA educational assistance under Chapter 30 - the All-Volunteer Force Educational Assistance Program, Chapter 32 - the Post-Vietnam Era Veterans Educational Assistance Program, Chapter 34 - Veterans Educational Assistance, and Chapter 35 - Survivors' and Dependents' Educational Assistance. Subsequent legislation provided eligibility for such counseling services to members of the Selected Reserve and those under Chapter 106 of title 10, USC, for active duty members under Public Law 96-342 and veterans under the Job Training Act of 1983. More recently, Public Law 98-543, enacted in 1985, added two four-year pilot programs for certain disabled veterans. One required those service-connected veterans awarded total ratings based on individual unemployability to undergo an evaluation to determine if a vocational goal is feasible or not. A similar program of evaluation was established for veterans awarded nonservice-connected disability pension. Participation in the evaluation process was mandatory for those veterans 50 years of age and under. For veterans over the age of 50, participation in the evaluation process was optional. The results of this program will be discussed in more detail in the course of our comments on the proposal of S. 2459 to extend the eligibility period for participation in the pilot program of vocational training for nonservice pension recipients to January 31, 1990.

With respect to the current operation of the vocational rehabilitation program, then as now, our experience, including that of The American Legion's Department Service Officers across the country, in assisting service-connected disabled veterans with their vocational rehabilitation claims has not involved a large number of complaints. The American Legion's efforts have been primarily in the area of outreach to potentially eligible veterans by way of providing information on the program and how and where to apply. Part of this outreach effort is directed toward potential employers in seeking their support for hiring disabled veterans. We believe the small number of complaints speaks well for the level of service being provided veterans by the staff of the Vocational Rehabilitation and Counseling Service. However, based on information contained in various VA reports, there are a number of issues of particular concern which merit this Committee's attention.

According to the VA's own reports, the workload of the Vocational Rehabilitation and Counseling Service has remained at fairly high levels in recent years. The number of veterans in the evaluation and planning phase of the program has been increasing in each of the last three fiscal years. It has risen from about 4,400 in 1985 to about 7,590 in the current fiscal year. The number of disabled veterans actually receiving rehabilitation training or services, including employment assistance, has likewise been increasing over the same period from about 21,900 to 24,000. The number of individuals receiving educational counseling services has shown a downward trend and is projected to stabilize at about 5,500 for this and next fiscal year. Staffing in the Vocational Rehabilitation and Counseling Service for FY 1985 was 597 FTEE. In FY 1986 it decreased to 580 FTEE and for FY 1987 it was up to 639 FTEE. Average employment for FY 1988 was estimated to be 661 FTEE. However, the budget request for FY 1989 called for a decrease of 11 FTEE down to 650. The VA's budget message for FY 1989 states that, "The requested FTEE level for 1989 will provide continued good service to our veterans." It further states, that "The proposed reduction in employment reflects the estimated resources needed to accomplish anticipated workload and to provide acceptable levels of service to veterans."

Mr. Chairman, from a review of the workload data The American Legion believes that disabled veterans are not receiving "good" service, under present conditions. The rise in the overall number of veterans availing themselves of Chapter 31 services in the period 1985-1987 has resulted in substantial increases in the number of days required to complete the various steps in the vocational rehabilitation process. Initial processing time for an application for Chapter 31 benefits has gone from 78 days in 1985 to 90 days in 1987. The evaluation and planning step which required 45 days in 1985 was up to 58 days in 1987. Extended evaluation for severely disabled veterans went from 154 to 182 days. The period of rehabilitation to employability was 345 days in 1985. In 1987 it was 454 days; an increase of more than 100 days.

Such data confirms a continuing and substantial deterioration in the timeliness of action in Chapter 31 cases. In the same period, there was a corresponding increase in the number of cases for which an individual Vocational Rehabilitation and Counseling specialist was responsible. This went from 170 cases in FY 1986 to 181 cases in FY 1987. In our judgment, the personnel resources of the Vocational Rehabilitation and Counseling Service have been stretched to the limit. The quality of service provided disabled veterans cannot help but be adversely affected. It now takes far longer to get evaluated, and then once enrolled in the program subsistence benefits are slow in starting. Experience has shown that such delays and holdups at the beginning of any such program have a significant impact on the veteran's motivation and attitude. Increasingly there is a lack of communication, supervision, or follow-up by the Vocational Rehabilitation and Counseling staff due to the heavy caseload, which causes many veterans to drop out or fail to complete their planned program. It is the veteran who is trying to overcome the handicap caused by his or her service-connected disability who suffers, as a result.

The ability of the Vocational Rehabilitation and Counseling Service to provide timely and comprehensive services has also been severely strained, in our opinion, by the curtailment of training activity for the professional staff due to budgetary restrictions on the Department of Veterans Benefits. The long-awaited modernization of the TARGET system for processing and paying Chapter 31 participants has yet to be fully implemented. In the critical area of employment and post-employment follow-up, because of limited staffing resources and training, the VR&C Service has not been able to fully provide disabled veterans with the necessary types of employment assistance and services to assure their suitable placement and retention of employment. Greater coordination with state and Federal employment services, particularly those of the Department of Labor, would help greatly to improve the level of direct service available to veterans in the Vocational Rehabilitation Program.

S. 2459 proposes to extend the temporary program of vocational training for certain pension recipients until January 31, 1990. This program was established in 1985, under Public Law 98-543, and required veterans under the age of 50 who were awarded disability pension in the period February 1, 1985 to January 31, 1989 to undergo an evaluation to determine whether or not a vocational goal is feasible and to authorize provision of vocational training and employment services for such veterans. Veterans over the age of 50 who were awarded pension in this period may elect to receive this evaluation and participate in vocational training. The total number of vocational evaluations is currently capped at 3,500 per year.

The VR&C Service reports that following a slow start in the first year, the activity in this program has increased significantly. Over the past three years a total of some 6,655 individuals have been evaluated. Approximately one-third of the veterans under the age of 50 who were evaluated have been found feasible. Of those veterans over the age of 50, 607 requested evaluation and 282 were found feasible. Of those, 140 elected vocational training or employment services. Overall, there are some 470 veterans who have pursued or are still in a program of training or services. The overall number of vocational evaluations for pension recipients is estimated to remain at a fairly high level during the remainder of the program period.

The American Legion supported the enactment of Public Law 98-543 and we believe the VR&C Service has done a commendable job in accommodating this additional responsibility into their Chapter 31 workload. While the program appears to be accomplishing its intended purpose, it has to some degree contributed to the slippage in timeliness reported in the Chapter 31 program. The American Legion is concerned that the VR&C Service will be unable to address this problem without additional staffing resources, particularly if the proposed extension of the pilot program of vocational evaluation for pension recipients is adopted. We would, therefore, offer qualified support for S. 2459.

With respect to the provisions of S. 2464 to authorize the VA to pay interest on delayed settlements and increase the discounts for insureds who pay their premiums in advance, The American Legion supports both proposals as they appear to be actuarily sound and require no substantive increase in program costs.

When government life insurance proceeds become payable, either through the death of an insured or as a matured endowment, and are held up in payment due to appeals, contests or other reasons, it is only fair that the beneficiaries receive an interest compensation as is now standard throughout the Life Insurance industry. In the past, as settlement monies are kept in the general insurance funds and earn interest therein, such interest proceeds were paid in the form of augmented dividends to the general body of policyholders, rather than to the beneficiaries whose property they should have become when the policies matured and became payable. This change then, while overdue, is thoroughly equitable and should be enacted into law, with the applicable interest rate being held at the same level as that earned by living policyholders on their dividend credit and deposit balances. This has been included in the VA proposal and would ensure equal treatment to all groups within the various program issues.

In regards to increasing the level of premium discounts as a more fair compensation for the prepayment of premiums, to an initial 7.5% level from the current level of 2.5 to 3.5%, those who now prepay are in effect increasing the returns (dividends) to all the other policyholders with the interest earned on this portion of their overall premium payment, especially as the insurance fund investments presently yield an approximate 9.6% return. Those who prepay are not deriving a fair compensation for doing so at the current discount level, and under current economic conditions. As the proposal includes both an adjustment to this imbalance, and a provision for similar changes in the future as yields on the insurance funds change over time so that fair compensation for prepayment is maintained on a continuing basis, The American Legion supports this section.

Moving now to the Veterans Housing Amendments Act, S. 2149 we have several brief comments.

First, as we have testified on previous occasions, The American Legion opposes negotiated interest rates for the VA Home Loan program. It must be remembered that the interest rate at present is established by the Administrator and is a maximum rate. Lenders are already free to charge lower interest rates if they so choose. Thus, the effect of this proposal can only be to grant license to lenders to charge higher rates. In addition, in other forms of financing, there is a direct correlation between the size of a down payment and the rate of interest. In fact, most conventional mortgages require a down payment of at least ten percent. We thus believe that the loser would be the first-time home buying veteran - precisely those who need the Loan Guaranty program the most. Mr. Chairman, it is the belief of The American Legion that if this proposal were adopted, the no down payment feature of the VA Home Loan program would be seriously jeopardized.

Second, with regard to the provisions of the bill governing the sales of vendee loans, we believe these changes may be a step in the right direction, since it has been clearly shown in recent studies by the General Accounting Office, that sales currently conducted without recourse have not been cost-effective. We suggest that the Congress should require a report from the VA which would summarize the results of the Administration's review of the experience of other Federal agencies, and the research conducted by the agency into market strategies such as overcollateralized loans or private reinsurances.

The last set of provisions in S. 2419, pertaining to the repeal of certain manufactured home loan requirements, appear to be warranted in light of the provisions of the National Manufactured Housing Construction and Safety Standards Act of 1974, which requires the Department of Housing and Urban Development to certify compliance with Federal manufactured home construction and safety standards. VA standards and inspections appear to be a duplication of effort, and agency resources in the Loan Guaranty function could be more effectively used in other areas, such as property management

Mr. Chairman, that concludes our statement.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS
June 16, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I appreciate this opportunity to appear here today to present our views on legislation relating to the Veterans Administration's health care system, loan guaranty and insurance programs.

Mr. Chairman, your letter of invitation to testify solicited our views relating to numerous pieces of legislation requiring this Committee's action and attention.

Our testimony has been requested regarding the following bills: S. 2207; S. 2293; S. 2294, the proposed "Veterans Administration Health Care Amendments Act of 1988;" S. 2394; S. 2396; S. 2419, the proposed "Veterans Housing Amendments Act of 1988;" S. 2446; S. 2462, the proposed "Veterans Administration Health-Care Personnel and Programs Act of 1988;" S. 2463; and S. 2464.

S. 2207

This bill, introduced by Senator Murkowski, Ranking Minority Member of the Committee, proposes to amend Section 614, Title 38, United States Code (38 USC), granting authority to the Administrator to provide "assistive animals" to quadriplegic veterans entitled to disability compensation.

Mr. Chairman, we are in agreement with the perceived intent of S. 2207; to assist disabled, especially severely disabled veterans, in pursuing a more independent life while also assisting in their rehabilitation, and recreational activities, as well as the contemplated positive psychological factors that may ensue.

Although the DAV has no official position on this bill, we believe clarification of a veteran's eligibility for being provided an "assistive animal" should be stipulated as a veteran service-connected for quadriplegia.

S. 2293

Introduced at the request of the Administration, this measure proposes to amend Section 5004(a)(4), 38 USC, with a corresponding amendment to Section 5002(d) to raise the VA's minor construction cost limitation from $2 million to $3 million.

In our view, increasing the minor construction cost limitation may be warranted in view of the decreasing purchasing power realized by the VA based on inflation over the preceding eight years since the limitation was last increased. Additionally, removing such a constraint may very well enable the VA to more expeditiously fund certain priority projects that would otherwise fall into the major construction account.

Although the DAV has no official position on this bill, we have no objection to its favorable consideration.

S. 2294

The "Veterans Administration Health Care Amendments Act of 1988"

Introduced at the request of the Administration, Section 2 of the measure proposes amending Section 620A, 38 USC, to make permanent the VA's authority to provide treatment and rehabilitation services for alcohol or drug abuse disabilities in community facilities, such as halfway houses, as well as eliminate the requirement that the VA monitor and maintain detailed records of the performance of the program by deleting Subsections (e) and (f).

Mr. Chairman, the VA has recently transmitted its final report -- as mandated by Public Law 99-166 -- to the Congress on the evaluation study of the contract program for veterans with alcohol and drug dependence disorders.

Following our review of this program evaluation, we are persuaded the program functions as an important augmentation to the VA's overall treatment of veterans suffering substance abuse disabilities. Therefore, the DAV has no objection to favorable consideration of this provision.

Section 3 proposes amending Section 620B(c), 38 USC, to extend the VA's authority to furnish respite care, for two years, through September 30, 1991.

Respite care is provided to certain terminally or chronically ill veterans via periods of brief, planned hospitalization that allows the primary caregiver, most often a family member, to have a "break" from the necessity of providing constant care and monitoring of the veteran.

Mr. Chairman, in our view, this program provides an enhanced quality of life for severely disabled veterans by allowing them to reside in the familiar surroundings and comfort of their own homes. Additionally, it provides incentive for the primary caregiver to continue to provide such care and, simultaneously, contribute to a reduced incidence of hospital and nursing home admissions for long-term care.

For these reasons, Mr. Chairman, we support this provision.

Section 4 proposes appropriate amendment to Section 628(A), 38 USC, to clarify the VA's authority to pay for emergency medical services for veterans participating in a vocational rehabilitation program under Chapter 31, 38 USC, when needed medical services are not feasibly available through VA or other government facilities.

Mr. Chairman, because certain veterans enrolled in the Vocational Rehabilitation Program are not now eligible for coverage of emergency medical care and in order to insure consistency, we do not necessarily object to this section.

However, we believe there exists a category of veterans who are equally deserving to be considered for reimbursement by the VA of certain expenses incurred in the provision of emergency medical care.

Specifically, we refer to former prisoners-of-war (POWs).

As you know, Mr. Chairman, former POWs have statutory entitlement to inpatient hospital care at VA medical facilities for any disability for which treatment is required (Section 610(a)(1)(F)). Also, medical services are authorized to be provided to POWs on an ambulatory or outpatient basis, as needed, at VA medical facilities (Section 612(a)(3)(A)).

We believe the current statutory scheme providing POWs health care services at VA medical facilities is in keeping with this Committee's and Congress's recognition of the extreme hardships endured by this small, albeit distinguished, category of veterans.

In our view, further amendment to Section 628(a)(2) deserves careful consideration by the Committee to include POWs in the list of veterans who may be considered for entitlement to reimbursement from the VA for the cost of medical care received when an emergent situation arises. (Such action would satisfy DAV Resolution No. 262.)

Section 5 proposes, via appropriate amendments to Section 632, 38 USC, to extend the authority for grants to the Veterans Memorial Medical Center, Republic of the Philippines, until September 30, 1994, and to require the sum of $50,000 of grant monies be used for education and training of health service personnel working at the Medical Center.

The DAV has no official position regarding Section 5. However, we would not object to its favorable consideration.

Section 6 proposes to amend Section 641(a), 38 USC, to increase the per diem rates paid by the VA to states for the care of veterans in state veterans homes.

Mr. Chairman, with the enactment of Public Law 100-322, the per diem rates paid to state veterans homes for domiciliary, nursing home and hospital care have been substantially increased effective October 1, 1988, as well as authorizing such increases to occur on an annual basis.

We believe the enactment of Public Law 100-332 will adequately reimburse the states for an appropriate portion of the care provided to eligible veterans. Additionally, by authorizing future per diem increases on an annual basis, we feel the adequacy of payments will be enhanced in the future.

Section 7 proposes certain amendments to the Health Professional Scholarship Program.

Section 8 proposes adding a new section -- 4147, 38 USC -- establishing a tuition reimbursement program for nurses employed by the VA.

Mr. Chairman, enactment of Public Law 100-322 has effectively satisfied the intent of Sections 7 and 8, making further discussion or comment unnecessary at this time.

Section 9 proposes appropriate amendment to Section 5033(a), 38 USC, extending, for three years, the VA's authority to provide grants for the construction, acquisition, expansion, remodeling and alteration of state veterans homes.

Mr. Chairman, the DAV supports this provision.

Section 10 proposes to extend, until September 30, 1991, the date by which the VA must report to Congress on their evaluation of the respite care program. The DAV has no objection to this provision.

Section 11, relating to the effective date of per diem increases for state veterans homes has been satisfied by enactment of Public Law 100-322.

S. 2394

Introduced at the request of the Administration, this measure proposes amending Section 4106, 38 USC, to permit the VA to hire trained graduates in certain health care professions or occupations without regard to civil service hiring procedures.

Mr. Chairman, as we understand it, this appointment authority would be limited to individuals who served under an appointment in a VA health care facility, in a clinical education program, which was affiliated with an accredited college or university. Additionally, preference would be extended to hiring of veterans.

Mr. Chairman, in our view, this measure would enhance the VA's ability to recruit certain allied health professionals by removing certain constraints encountered when proceeding through the normal civil service hiring practices. Therefore, the DAV has no objection to favorable consideration of this measure.

S. 2396

Introduced by a distinguished member of the Committee, Senator Mitchell, this measure proposes amending Section 101(29), 38 USC, modifying the beginning date of the Vietnam Era from August 5, 1964, to February 28, 1961, for those veterans who served in the Republic of Vietnam during such period.

Although the DAV has no official position on this measure, we would not object to its enactment.

Also, Mr. Chairman, veterans who served in Vietnam between February 28, 1961, and August 5, 1964, are not the only category of veterans exposed to combat, being denied wartime VA benefits and status. For example, individuals who served subsequent to the official ending date of Vietnam -- May 7, 1975 -- in such places as Iran during the hostage crisis, Lebanon, Grenada, as well as the current hostilities in the Persian Gulf and Central America, are not entitled to VA benefits reserved for wartime service.

Therefore, it would seem logical -- and equitable -- to also extend wartime status to all military personnel who served in an area where they may be exposed to combat situations. Perhaps, S. 2396 should be amended to include all veterans who served during the proposed Vietnam Era, as well as all military personnel who served in an area of the world where there exists a likelihood of being involved in combat or hostile situations.

S. 2419

"Veterans' Housing Amendments Act of 1988"

Introduced at the request of the Administration, S. 2419 proposes, through various amendments to 38 USC, to:

1. Require negotiated interest rates on VA guaranteed home loans;

2. Repeal the requirement that prohibits the VA from selling vendee loans without recourse after October 1, 1989, unless sold at par;

3. Alter certain manufactured home loan requirements;

4. Repeal the requirement that prohibits the VA from guaranteeing loans in areas where public and community water and sewage systems are not established, but are determined to be feasible;

5. Permit an offset of federal tax refunds for VA housing loan debts; and

6. Impose a time limit of 180 days, after receiving notice of a housing loan debt, for a veteran to request a waiver from the VA on the debt.

Mr. Chairman, the DAV recognizes the serious problems besetting the VA Home Loan Program and, in all candor, we find this Administration proposal severely lacking in any rational amendments to improve the present situation.

For example, the proposals to remove the Administrator's authority to set interest rates on VA guaranteed loans and repeal the current statutory requirements regarding the sale of vendee loans clearly reflects the Administration's true intent -- to curtail and eventually eliminate the VA Home Loan Program.

There is no doubt that the OMB dictated "selling off" of the VA's portfolio has adversely impacted on the solvency of the VA's Loan Guaranty Revolving Fund. Furthermore, should the Administrator's authority to set interest rates on VA guaranteed home loans be removed, interest rates would then be dictated by mortgage lenders at, we suspect, a level significantly higher than would be set by the Administrator. Without doubt, all veterans, including service-connected disabled veterans, would be adversely affected by such a change.

In addition, we also note in Section 6 of the bill that the Administration is proposing to offset federal tax refunds to collect VA home loan debts -- a procedure for which, as we understand, they already have authority.

Mr. Chairman, the DAV strongly urges the Committee to completely reject the provisions of S. 2419.

S. 2446

Introduced by a distinguished member of the Committee, Senator Rockefeller, this measure -- like Section 3 of S. 2294 -- proposes amending Section 620B(c), 38 USC, extending the VA's authority to furnish respite care. As previously indicated, the DAV supports extending this program.

S. 2462

The "Veterans Administration Health-Care Personnel and Programs Act of 1988"

Introduced by yourself, Mr. Chairman, Section 2 proposes appropriate amendment to Section 612A, Title 38, USC, regarding eligibility for readjustment counseling and related mental health services to certain veterans who:

* served on active duty after May 7, 1975, in an area during a period in which hostilities occurred; or

* served on active duty during World War II or the Korean Conflict.

Mr. Chairman, we have no objection to expanding eligibility for readjustment counseling to those veterans who served on active duty after May 7, 1975, and were subjected to the dangers of hostile or armed conflict comparable to the dangers experienced by military personnel in battle with the enemy during a period of war.

Likewise, we have no objection to expanding eligibility for readjustment counseling services to World War II or Korean Conflict veterans.

Section 3 proposes extending the VA's authority to make grants to the Veterans Memorial Medical Center, Republic of the Philippines, until September 30, 1992, for the purposes of assisting in the replacing and upgrading of equipment and in rehabilitating the physical plant and facilities of the Medical Center.

As previously discussed -- Section 5, S. 2294 -- we have no objection to this provision.

Mr. Chairman, Section 4 is virtually identical to S. 2394 and, therefore, we have no objection to favorable consideration.

Section 5 proposes appropriate amendment to Section 4107(g)(4) to require the Director of the Office of Personnel Management (OPM) to act upon a request for special salary rates for VA employees, hired under Title 5 authority, within 45 days from the receipt of such a request from the Veterans Administration.

Mr. Chairman, the vital importance of special salary rates for VA employees providing health care services cannot be overemphasized. This authority is a major tool used in the recruitment and retention efforts in hiring difficult to find health care professionals.

The DAV is supportive of any reasonable effort to alleviate the crucial health care employee shortages occurring within the system. Short of relieving the VA from the requirement to achieve OPM appeal and the incomprehensible delays sometimes encountered in having special salary rates approved, a reduction of the time required by OPM to decide on the VA's request is a positive step.

Mr. Chairman, the DAV has no official position regarding disciplinary actions or grievances as outlined in Section 6.

Section 7 proposes amendment to Sections 5051 and 5053, 38 USC, regarding the sharing of specialized medical resources by expanding the types of medical facilities which the Administrator is authorized to enter into agreements with in order to share the most advanced medical techniques, information and certain specialized medical resources.

The DAV has no official position regarding this provision, however, if veteran patients will potentially benefit from such an expansion of authority, we could be supportive of its favorable consideration.

Section 8 proposes amending Section 5091, 38 USC, as well as adding a new section -- 5094, 38 USC -- authorizing appropriations of $5 million for each of Fiscal Years 1989 and 1990; and $6 million for each of Fiscal Years 1991 and 1992 for the purpose of the VA assisting various institutions in establishing cooperative arrangements for the education and training of certain health care personnel.

Mr. Chairman, as we understand it, the intent of this provision is to assist in alleviating, to some degree, the severe health care personnel shortages currently plaguing the medical community, particularly the VA. If enactment of Section 8 will, indeed, offer assistance in this area, the DAV has no objection to its favorable consideration by the Committee.

Section 9 proposes to direct the Chief Medical Director to conduct a three year pilot program, at not less than five VA medical facilities, with respect to various pay and management practices relating to the recruitment and retention of registered nurses and other scarce health care professionals.

Mr. Chairman, as previously discussed, the DAV is keenly aware of the shortage of health care personnel in the various medical disciplines. If this provision helps to remedy the situation in the VA health care system, we could lend our support to the proposed pilot projects.

Finally, Section 10 would require the submission of a report by the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder relating to that Committee's evaluation of the results of the study -- reportedly scheduled for completion by October 1, 1988 -- required by Section 102 of Public Law 98-160.

Mr. Chairman, the DAV has continually expressed our commitment toward assisting Vietnam veterans suffering psychological problems associated with their military service. As you know, the DAV provided funding as early as 1976 for "The Forgotten Warrior Project," a study which led, in October 1978, to the DAV initiating our Vietnam Veterans Outreach Program. We feel it was, in large measure, due to our efforts that the VA created their current network of Vet Centers.

It is very discouraging and frustrating that the VA and the entity contracted to conduct the study -- Research Triangle Institute, Incorporated -- have had such difficulties and permitted the timetable to complete the study to be severely delayed by almost two years.

Mr. Chairman, the DAV is anxious and eager to review this study, as well as any additional analysis or comment that may ensue after its completion. In this regard, we feel the provisions of Section 10 may prove beneficial.

S. 2463

Introduced by yourself, Mr. Chairman, this measure proposes adding a new subsection -- (g) -- to Section 4104, 38 USC, directing the Administrator to designate not more than five VA health care facilities as centers for Mental Illness Research, Education and Clinical Centers (MIRECCs).

The stated purpose of S. 2463 is to improve and expand the VA's capabilities to provide the most appropriate and effective treatment to veterans suffering psychiatric illness, especially as it relates to their military service; to advance scientific knowledge regarding mental illness through a program of research; and develop improved methods of treatment, as well as provide training activities for health care professionals involved in the treatment of psychiatric illness.

Mr. Chairman, several years ago, a decision was made by the VA that psychiatric inpatient care would be considered acute care and thus be subject to the Diagnostic Related Groups (DRGs) based Resource Allocation Methodology (RAM). This was implemented despite serious concerns that psychiatric care could not be accurately estimated in this manner.

Since that time, a variety of serious, negative consequences have ensued by utilizing the DRG methodology. Veterans' lengths of stay cannot be accurate predicted, nor can a clear distinction be made between chronic and acute psychiatric illness.

As a result of an inappropriate RAM, as well as other factors, VA psychiatric resources have suffered immensely in years past.

Mr. Chairman, it has been estimated that approximately 40% of all VA bed days are concentrated on veterans suffering from some form and degree of mental illness. Yet, the total dedicated dollars to provide such care or engage in related research is extremely small and disproportionate.

Though the DAV has no official position relating to S. 2463, we could be supportive of its favorable consideration by the Committee.

However, as we read this measure, there appears to be language contained therein which we feel requires deletion and/or modification.

Specifically, we refer to paragraphs three and four of the proposed new Subsection (g) of Section 4101, Title 38, USC, regarding the allocation of funds to be used for the establishment of MIRECCs.

Mr. Chairman, the DAV is a strong advocate for a viable research component, especially rehabilitation research and development (RR&D) within the Department of Medicine and Surgery.

For many years, we have been concerned with what we view as a somewhat meager and certainly disproportionate funding level for RR&D when compared to basic medical research. While we fully support adequate funding of the VA's research program, we are especially supportive of RR&D, as we feel there exists a tremendous potential to meaningfully address and assist in meeting the needs of severely disabled veterans, especially as it relates to combat-incurred disabilities, such as amputations.

This measure's current construction raises a concern that already scare funds may be withheld from RR&D in order to fund mental illness research.

In our view, specific funds should be appropriated and dedicated expressly for the purpose of meeting the intent of this measure. This position becomes more apparent in view of Section 135, Public Law 100-322, designating mental illness as a specific research mission of the VA.

S. 2464

Introduced at the request of the Administration, S. 2464 seeks to amend 38 USC, for the purposes of:

1. Paying interest on policy proceeds from participating National Service Life Insurance (NSLI), Veterans Special Life Insurance (VSLI), Veterans Reopened Insurance (VRI) and United States Government Life Insurance (USGLI) for the period from the date of death to the date of payment or, in the case of an endowment policy, from the date of its maturity to the date of payment; and

2. Adjusting the discount rates for insurance premiums paid in advance on National Service Life Insurance (NSLI), Veterans Special Life Insurance (VSLI) and Veterans Reopened Insurance (VRI) policies.

The Administration has stated, with respect to paying interest on policy proceeds -- "although claims are generally paid within ten days from the date of receipt in the VA, in some cases, a significant period of time elapses between the date when life insurance proceeds become payable and the date when the actual payment is made."

Under the VA's current practice, settlement proceeds remain invested, primarily in U.S. Treasury securities, and any interest earned is then distributed to policyholders in the form of dividends.

It appears that the Administration believes it is more equitable to pay interest on the proceeds to beneficiaries in those cases involving lengthy delays in payment and they claim this would be consistent with a standard practice in the commercial life insurance industry.

However, the Administration has pointed out there would be a "small impact" on the payment of dividends to policyholders as a result of paying settlement interest from the annual dividend distribution.

The other provision of the legislation seeks to extend the Administrator's authority to adjust discount rates for insurance premiums paid in advance. Those rates currently range from 2.5% to 3.5%, depending upon the individual program.

Apparently, the Administration is seeking to encourage greater numbers of policyholders to pay premiums in advance by offering a greater discount. They propose to increase the premium discount initially to 7.5%, but never less than those currently in effect.

Further, the Administration claims they will realize some Administrative savings from this proposal, but such savings will not be significant.

Mr. Chairman, the DAV has no official position with respect to the proposals embodied in S. 2464, however, as it appears they may be of benefit to veterans and beneficiaries of veterans, we urge the Committee to consider them carefully.

Mr. Chairman, this concludes my statement and, once again, I would like to extend the DAV's appreciation for allowing us to appear here today to discuss these most important issues.

STATEMENT OF
RONALD W. DRACH
NATIONAL EMPLOYMENT DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS
June 16, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I would like to thank you for giving us this opportunity to provide comments on the VA's Vocational Rehabilitation Program.

The DAV is grateful to you, Mr. Chairman, and the members of this Committee for holding these hearings. Your willingness to do so obviously reflects the sincere ongoing interest and concern of the Committee, as well as your desire to review and assess the various employment programs and their impact on this nation's disabled veteran population.

This Committee has been a leader in monitoring the activities regarding employment services to our veterans. This is most evident by the enactment into law of S. 999 last month which, as you know, Mr. Chairman, is a major rewrite of the employment services provisions of Chapter 41, Title 38, U.S. Code. This Committee and its staff, along with the House Veterans Affairs Committee and its staff, have chiseled out a piece of legislation that, in our opinion, will be widely accepted as the major piece of employment service legislation to be enacted since Public Law 92-540 in 1972. We thank you for your leadership and strong support.

As you know, Mr. Chairman, it has been very difficult to actually quantify the unemployment rate among disabled veterans because so little data are available for this group. There have been studies, reports and estimates on unemployment and we believe the results reflect that, even in the best of times, a totally unacceptable rate of unemployment exists among our nation's disabled veterans.

Mr. Chairman, the DAV was founded on the principle that this nation's first and foremost duty to its veterans is the rehabilitation and the providing of adequate health care for our wartime disabled. Our membership, composed of honorably discharged veterans who were disabled during wartime military service to our country, has continually supported adequate vocational rehabilitation training. We have long believed that this type of training is necessary to assure the disabled veteran an easy transition into civilian life. It is also necessary, Mr. Chairman, to have this type of program available for those who, for whatever reason, experience an increase in their disability which may preclude them from continuing in their normal occupation. Congress has provided benefits for these individuals in order that they may be retrained at subsequent dates.

Vocational rehabilitation, as we know it today, was originally established by Public Law 78-16 enacted shortly after World War II. From its inception, the program always had as its goal the restoration of employability. Mr. Chairman, the DAV, as well as others in the veterans' employment community, believe that goal to be insufficient. In 1980, Public Law 96-466 made significant changes and improvements in the Vocational Rehabilitation Program. One of the most important changes emphasizes the attainment of actual employment. After almost 40 years of institutionalized thinking about "restoration of employability" the rules were changed. Since the changing of these rules, very little employment services training has been provided to the vocational rehabilitation staff.

Section 1500, titled "Purposes," of Chapter 31, Title 38, U.S. Code, now states, in part, "the purposes of this chapter are to provide for all services and assistance necessary to enable veterans with service-connected disabilities...to become employable and obtain and maintain suitable employment."

Mr. Chairman, the DAV is satisfied with the legislative intent of Public Law 96-466. We are not pleased, however, with the accomplishments of those amendments. In part, our dissatisfaction stems from the fact that caseloads have increased while at the same time additional administrative duties and direct labor intensive services have been established and a decrease in the number of personnel has occurred.

In Fiscal Year 1982 the Vocational Rehabilitation and Counseling Service had the equivalent of 629 FTEE field personnel and by Fiscal Year 1989 that figure will decrease to 568.

Mr. Chairman, our opinion is that it is most inadvisable to increase the responsibilities and scope of the program, as was necessary in 1980, while concurrently decreasing the resources available to carry out those mandated changes. That in itself presents a major roadblock to successful implementation of any legislation.

Mr. Chairman, in preparing for today's hearing, I reviewed several documents including a recent audit by the Office of the Inspector General. That audit certainly raises some questions about the adequacy of providing employment services. However, we view the IG audit as one that was designed to tear down the program rather than to review and make good solid recommendations on assuring that quality services are provided to our nation's disabled veterans. It appears that the audit is designed to save money rather than to save people. We will be taking a closer look at that study, but I believe, based on my initial review, that the recommendations have little merit.

Mr. Chairman, I do, however, suggest for your reading a report of the Employment Services Task Group set up under the Vocational Rehabilitation and Education Service. This group is comprised of three field staff and several national office staff. They have met on two occasions at Central Office and had several conference calls. They have identified 36 problems that impact on the delivery of employment services.

Mr. Chairman, this is a study undertaken by professionals in the field rather than auditors. I believe the task group's report should be looked at very closely as many of the problems will require some legislative, as well as regulatory changes.

Mr. Chairman, I was asked several years ago to chair the Administrator's Advisory Committee on Rehabilitation. This Committee has recently directed its attention to vocational rehabilitation. I will be asking the members of the Committee to review the task group's report and further request the Advisory Committee adopt, if appropriate, their recommendations. If our Committee does so, we will make our recommendations formally to the Administrator of Veterans Affairs. That Committee will be meeting next week. I put much creditability in this report since it was an objective evaluation of their own program. I believe it is staffed by extremely dedicated individuals who want to comply with what is morally and legally appropriate.

Mr. Chairman, I would like to discuss a couple of problems that I believe are very important. The task group looked at the lack of motivation for veterans to work, as well as certain disincentives to employment. I was very pleased to see them look at this issue since it is one that affects the disabled non-veteran population as well. It is not the first time it has surfaced in the disabled community. Most recently, the Social Security's Disability Advisory Counsel looked at work incentives/disincentives for disabled people in a very comprehensive manner. I can assure you that it is a very complex issue and one that will not be easily addressed. I encourage the task group to continue in its deliberations on this issue.

They identified the lack of support for employment services on the part of the Vocational Rehabilitation and Counseling Officer. This, in large part, is an attitudinal problem which in some ways may be as difficult to address as the work disincentive issue. I believe this can be best addressed by providing additional training and assistance in alleviating unnecessary or duplicative paperwork. I believe the reluctance of the VR&C Officer to support employment services is one based almost exclusively on other problems confronting the office.

Lack of training for the professional staff was another problem they identified. The Disabled American Veterans believes very strongly that employment services training for these individuals should be an integral part of future training programs. Prior to 1984, the DAV had never participated in a Vocational Rehabilitation and Counseling Service Training Program. It was in 1984 that Director Dr. Dennis Wyant invited us and other veterans' organizations to participate on a panel to help provide employment assistance training. This was a small but significant step toward providing needed training.

In-depth training, similar to that currently being provided to DVOPs and LVERs at the National Veterans' Training Institute, needs to be implemented for the VR&C staff. I cannot overemphasize our support for that type of training. The task group also identified the failure to focus on employment at the beginning of the VR process as a problem.

We suggest that a review be made to determine the feasibility of developing an individual employment assistance plan (IEAP) at the very outset. We believe this approach to be very sound and suggest that if both the Rehabilitation Specialist and the veteran knew step-by-step what was expected and had intermediate goals established, this could prove to be very successful.

Insufficient incentives for staff to provide effective employment services was a problem they identified and the previously mentioned IG audit certainly helps to exacerbate that problem. The IG audit had nothing positive to say about the hard work and dedication of the VR&C staff, nor did it once mention any particularly successful programs of more severely disabled veterans.

Mr. Chairman, I don't think there is any question that employment services for disabled veterans of the Vocational Rehabilitation Program can and should be improved. I believe we should look very closely at the Employment Services Task Group's recommendations, as it is obvious that much thought and work went into them. Those areas that require legislative action should be scrutinized and those that require administrative or regulatory action should be treated likewise. I am sure many of the recommendations can be implemented with little or no cost and we should ask the Administrator to review and respond to the recommendations.

Mr. Chairman, there is another area that needs to be reviewed. Several weeks ago in an appearance before the Subcommittee on Compensation Pension and Insurance of the House Veterans Affairs Committee, we said we would not object to extending Vocational Rehabilitation Program for certain pension recipients, provided it did not impact adversely on the service-connected program.

Mr. Chairman, before you take any action on S. 2459, we urge you to carefully review the report which was due to be submitted to the Committee by April 15, 1988. I understand that you still do not have that report.

Mr. Chairman, attached to my statement is an analysis of the Vocational Rehabilitation and Counseling Program. This analysis is extracted from the so-called "Independent Budget." In essence, the question is not whether the program for pension recipients hurts the service-connected veteran, but whether enough resources and personnel are available to serve both groups.

Mr. Chairman, I have also attached to my prepared statement copies of Resolution Nos. 348, 349, 291, 346 and 356, adopted at our 1987 National Convention in Atlanta, Georgia. Resolution Nos. 348, 349 and 356, deal directly with Chapter 31.

Resolution No. 348 would require the VR&C staff to provide employment services to any service-connected disabled veteran who requests such services.

Resolution No. 349 supports additional staffing for the vocational rehabilitation staff to adequately fill positions of Job Placement Specialist.

Resolution No. 356 would permit state and local government agencies to participate in unpaid on-the-job training and work experience programs under Chapter 31.

Resolution No. 291 calls for the elimination of the delimiting date for eligible spouses and surviving spouses for benefits under Chapter 35, Title 38.

Resolution No. 346 would allow spouses who are in a program under Chapter 35 to participate in the Work Study Program.

Mr. Chairman, I believe all of these proposals are worthy of your consideration.

Mr. Chairman, in my daily work I am involved with quite a few non-veteran disabled organizations. The VA's Vocational Rehabilitation Program is generally looked at as a model. This is due, in large part, because it is an entitlement program. What is not known by the disability community is some of the problems we have outlined here today. I am very proud of the VA's Vocational Rehabilitation Program and pleased to be a product of it. I received my training as a DAV National Service Officer under Chapter 31 in the early 1970's. I can attest to the benefits it has provided me. We cannot allow the program to wither because of a lack of support by the Executive Branch. If we continue to cut staffing, the Vocational Rehabilitation Program in the VA will not be one for emulation.

Mr. Chairman, we have also identified a need to provide timely services to disabled veterans currently being transitioned from military service to civilian life. The Department of the Army has established a program called "Project Transition" but, as yet, has not provided any direct services to disabled military personnel. We have suggested that the Department of the Army integrate ongoing services to include vocational rehabilitation to those individuals who have potential eligibility. We think it would be very easy for the military services to identify those individuals and to refer them to the Veterans Administration soon enough before discharge so that vocational rehabilitation counseling services can be started early. We believe very strongly that this would go a long way toward providing an adequate and appropriate transition from military service for these individuals.

We also question the Administration's commitment from another view point. Although the mandate to provide employment services was enacted in 1980, it was not until 1986, that the Veterans Administration assigned individuals to specifically work on employment services. Two individuals were assigned to review cases and make recommendations to improve employment programs. They have, in a little over a year and a half, reviewed 600 cases to see if Congressional mandates are being carried out. When obvious errors are found, they are brought to the attention of the appropriate office for corrective action. They continue to perform these duties, yet were recently downgraded in their position by the current Administration. How can we expect people to carry out Congressional mandates only to have the Administration tell them that their duties are not important enough to maintain their present grade. We believe this needs to be looked at very closely.

Mr. Chairman, I am also informed that the timeliness of payments to disabled veterans in vocational rehabilitation is next to archaic. It is my understanding that the Vocational Rehabilitation Program is the only payment system that is currently maintained on the old manual system. This results in unnecessary delays in payments to beneficiaries. The Vocational Rehabilitation Program should be on the VA's computerized "Target System" to make timely payments.

In conclusion, we again appreciate your ongoing concern that our nation's veterans, who have incurred disability during their service to our country, receive adequate and meaningful employment services, including those through the Vocational Rehabilitation Program.

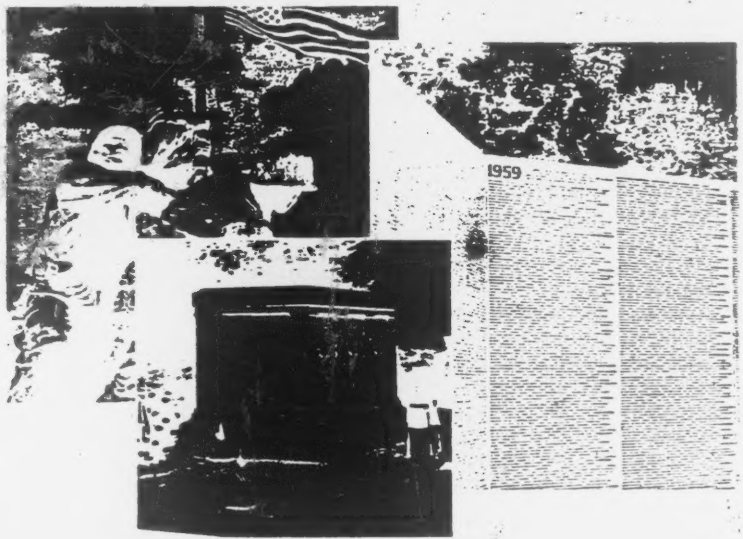
Mr. Chairman, we can provide adequate compensation, health care and other benefits, but if we do not assist those disabled veterans' transition to meaningful career employment, we have not truly rehabilitated nor transitioned these veterans into civilian life.

We look forward to working with you on these and other employment issues now and in the future.

MEETING THE CHALLENGE:

To Keep the Promise

An Independent Budget by Veterans for Veterans' Programs



Fiscal Year 1989

were made with private individuals (usually retired employees) to perform work on a fee basis. These management initiatives met with considerable success. For example, in May 1986 only 27 percent of VA appraisals were processed within VA's basic 15-day time standard, but by November 1986, 57 percent of the appraisals were meeting the timeliness standard.

These measures were, however, insufficient to adequately address the backlog problem, as the timeliness data indicate. We note with approval that the estimate of FY 1988 average employment to administer this program is 2,100—131 over the FY 1986 level of 1,969. This increase in the number of employees is, we think, desirable for several reasons. For one, the stop-gap measures taken in response to the upsurge in workload are disruptive to other programs and expensive (additional travel, contracting costs, and overtime). Second, they are "band-aid" approaches to a major problem that gives no indication of being quickly resolved—interest rates remain relatively low and economic conditions in the Southwest have not improved significantly.

Congress is also addressing problems in the loan guaranty program, most recently in P.L. 100-198. For example, that legislation includes, among others, a provision that would require the VA, to the extent appropriations are available, to provide personnel to implement improved service to veterans. It also makes a number of changes directed at problems of defaults, foreclosures, acquired properties, and loan management.

We are encouraged by these developments; they demonstrate that attention is being given to this program, both legislatively and administratively. However, we believe that additional resources must be provided to restore adequate service to veterans, particularly those who have defaulted on VA-guaranteed loans. Therefore, we are recommending that Congress authorize additional staff and funding at this time, solely for the purpose of providing immediate servicing of defaulted loans in an attempt to avoid foreclosure and reduce the program's liability.

Vocational Rehabilitation and Counseling: Increase staff to 714 FTEE at a cost increase of 1.6 million. The Vocational Rehabilitation and Counseling (VR&C) component of DVB provides assistance to veterans with service connected disabilities to help them achieve maximum independence in daily living, to become employable, and to obtain and maintain suitable employment. It also provides counseling services to veterans and members of the Armed Forces applying for educational and job training benefits and it operates career development centers. Its three main areas of activity are to provide: (1) Rehabilitation evaluation and planning; (2) Counseling and rehabilitation services; and (3) Employment services.

These services are among the most important in the entire veterans' benefits area. VR&C carries out the nation's commitment to help veterans disabled in military service—those to whom we owe most—to function independently and to obtain suitable employment. These services, moreover, are beneficial to the nation because they help restore disabled veterans to the status of economically productive, taxpaying workers.

Unfortunately, there are backlogs in the VR&C workload, due to inadequate staffing, which seriously undermine the effectiveness of the service VR&C provides. For example, a veteran must now wait 84 days, on average, from the time his application is received until he has an initial interview with a vocational rehabilitation specialist (VRS). This is an intolerable wait, especially as studies of successful vocational rehabilitation programs repeatedly show the critical importance of starting rehabilitation quickly—before negative attitudes about employability become established. In the short term, our goal is to reduce the wait to 30 days; for the longer term, even better performance is necessary and DVB should re-establish a presence in VA medical centers—such as it had in the post-WWII period. Among other things, such a presence will help VR&C to start contact with veterans needing vocational rehabilitation services at the optimal time—namely, early after hospitalization begins.

Other delays in VR&C services are occurring when vocational rehabilitation staff believe psychological counseling and evaluation is necessary.

Additional evidence of staffing shortages in VR&C include:

- An average workload of 182 cases for VA vocational rehabilitation specialists compared to a workload of 60 cases for comparable staff in the state/federal rehabilitation program.

- An increase from 155 days in FY 1984 to 232 days in FY 1986 in the average time from (1) the completion of a veteran's rehabilitation program and his readiness to seek employment until (2) he has been employed for 90 days, which is the point at which rehabilitation is counted as having succeeded.

In short, service to veterans in this important area is clearly inadequate. This has also been documented by General Accounting Office (GAO) and Inspector General (IG) studies completed in recent years.

Again the problem is caused by grossly deficient resources and a lack of training. For example, until approximately seven years ago, the VA was not involved in employment services. Before that time, once a veteran's vocational rehabilitation and counseling from the VA were completed, a veteran was on his own (or referred to the Department of Labor) for employment services. The VA has since become responsible for employment services, but no additional funds were provided. Vocational rehabilitation staff thus took on the new responsibility, but they have been overloaded with cases, and cannot devote appropriate time and attention to employment services.

We therefore note with approval the fact that VR&C has finally received authorization to create a new position of employment specialist. Currently, there are approximately 4,600 veterans needing employment services at any given time. We recommend a workload of 100 cases per employment specialist, or 46 FTEE for employment specialists in VR&C. This should finally provide adequate employment services. It will also generate some relief for rehabilitation specialists. However, to deal with the excessive backlogs and their very negative consequences, more staff is needed.

We therefore recommend increased staffing to provide one vocational rehabilitation specialist for every 125 rehabilitation cases and one counseling psychologist for every 20 active counseling cases; currently, the rehabilitation specialists carry an average workload of 182 cases, and the psychologists an average load of 25 cases. Despite this staffing increase, the vocational rehabilitation specialists will still be carrying more than twice the workload of their counterparts in the state/federal program.

We also want to emphasize an urgent need for training VR&C staff in their specialized work. Suitable training programs are available through contract with the Department of Labor.

ADP Systems Management: Actively manage systems modernization. The ADP Systems Management program is focused on the modernization of DVB's computer and telecommunication systems in order to provide better services to veterans and their dependents and survivors.

We have made several recommendations regarding the direction systems modernization should take; the manner of the specific implementation of these recommendations is a matter for VA management. The VSO's do, however, expect a realistic and cost-effective assessment of ADP needs by DVB. VA management must make a determination of whether a supplemental appropriation should be sought for ADP systems development. If a supplemental appropriation is appropriate, we urge the Congress to approve it.

We again emphasize the need for rapid modernization of DVB automated systems and the critical need for development of ADP links with the rest of the VA — and possibly other federal agencies—to provide the integrated, modern computerized systems needed to render timely and accurate service to veterans and to permit high-level productivity from DVB employees.

Support Services: Maintain current staff. The Support Services component of DVB provides administrative, finance, and personnel office staff to the rest of DVB. We find performance in this area more adequate than in others, and do not recommend an increase in staff or an increase in other resources beyond that needed to cover inflation.

DEPARTMENT OF MEMORIAL AFFAIRS (DMA)

The Department of Memorial Affairs (DMA), the second VA department funded by the General Operating Expenses (GOE) appropriation, carries out three main activities. For one, it inters deceased veterans, as well as members of the Armed Forces, their spouses, and certain dependents, in national cemeteries that have available grave space. Second, it provides headstones for these burials in national cemeteries and also for burials in private cemeteries. Third, it administers the program of grants to states for state veterans cemeteries.

Maintain current staffing. We recommend continuation of the present level of DMA staffing. As Chart III shows, the number of interments, headstones provided, and graves maintained each year is increasing rapidly as the veteran population ages, and current staff is able to keep up with this increasing workload only through increasing efficiency.

RESOLUTION NO. 348
LEGISLAIVE

REQUIRE THE VA'S VOCATIONAL REHABILITATION STAFF TO PROVIDE EMPLOYMENT SERVICES TO ANY SERVICE-CONNECTED DISABLED VETERAN WHO REQUIRES SUCH SERVICES

WHEREAS, the American labor force is experiencing rapid change due to changing technology and skill obsolescence; and

WHEREAS, service-connected disabled veterans frequently require assistance in finding suitable employment; and

WHEREAS, the VA employs counseling psychologists and vocational rehabilitation specialists in the vocational rehabilitation program who are qualified by education and experience to provide employment services; NOW

THEREFORE, BE IT RESOLVED that the Disabled American Veterans in National Convention assembled in Atlanta, Georgia, August 16-20, 1987 support legislation to require the VA vocational rehabilitation program to provide employment services to any service-connected disabled veteran who requests such services.

* * *

RESOLUTION NO. 349
LEGISLATIVE

. IN SUPPORT OF ADDITIONAL STAFFING FOR THE VOCATIONAL REHABILITATION STAFF TO ADEQUATELY FILL POSITIONS OF JOB PLACEMENT SPECIALISTS

WHEREAS, job placement specialists require highly technical and specialized skills in assisting individuals in obtaining suitable employment; and

WHEREAS, the VA's vocational rehabilitation program is mandated by Public Law 96-466 to provide employment services to disabled veterans in training under Chapter 31, Title 38, U.S. Code; and

WHEREAS, the VA's vocational rehabilitation staff has suffered reductions so as to severely hinder their ability to provide required employment services; NOW

THEREFORE, BE IT RESOLVED that the Disabled American Veterans in National Convention assembled in Atlanta, Georgia, August 16-20, 1987 support additional and adequate staffing for the vocational rehabilitation staff for the purposes of creating and filling positions of job placement specialists.

* * *

RESOLUTION NO. 291
LEGISLATIVE

ELIMINATE THE DELIMITING DATE FOR ELIGIBLE SPOUSES AND SURVIVING SPOUSES FOR BENEFITS PROVIDED UNDER CHAPTER 35, TITLE 38, U.S. CODE

WHEREAS, dependents and survivors eligible for VA education benefits under Chapter 35, Title 38, U.S. Code have ten years in which to apply for and complete a program of education; and

WHEREAS, this ten year period begins either from the date a veteran is evaluated by the VA as permanently and totally disabled from service-connected disabilities or ten years from the date of such veteran's death due to service-connected disability; and

WHEREAS, in many instances, because of family obligations or the need to provide care to the veteran, spouses or surviving spouses may not have had an opportunity to apply for these benefits; NOW

THEREFORE, BE IT RESOLVED that the Disabled American Veterans in National Convention assembled in Atlanta, Georgia, August 16-20, 1987 seek the enactment of legislation which would eliminate the delimiting date for spouses and surviving spouses for purposes of benefits provided under Chapter 35, Title 38, U.S. Code.

* * *

RESOLUTION NO. 346
LEGISLATIVE

ALLOW CHAPTER 35, TITLE 38, U.S. CODE RECIPIENTS TO PARTICIPATE IN THE WORK STUDY PROGRAM

WHEREAS, spouses, widows and surviving children of certain service-connected disabled veterans have eligibility for Chapter 35, Title 38, U.S. Code educational benefits; and

WHEREAS, a work study provision currently exists for veterans attending VA programs of education on a full time basis to supplement their education allowance, as well as provide work experience; and

WHEREAS, the absence of a similar work study program creates a gross inequity for the widows, spouses, and surviving children eligible for educational assistance under Chapter 35, Title 38, U.S. Code; NOW

THEREFORE, BE IT RESOLVED that the Disabled American Veterans in National Convention assembled in Atlanta, Georgia, August 16-20, 1987 support legislation to allow Chapter 35, Title 38, U.S. Code recipients to participate in work study programs.

* * *

RESOLUTION NO. 356
LEGISLATIVE

PERMIT STATE AND LOCAL GOVERNMENT AGENCIES TO PARTICIPATE IN UNPAID ON-THE-JOB TRAINING AND WORK EXPERIENCE PROGRAMS UNDER CHAPTER 31, TITLE 38, U.S. CODE

WHEREAS, Chapter 31, Title 38, U.S. Code, authorizes the VA to use federal agencies for unpaid on-the-job/work experience programs; and

WHEREAS, the unpaid on-the-job/work experience provision has proven to be a valuable option for certain disabled veterans in reaching their rehabilitation goals; NOW

THEREFORE, BE IT RESOLVED that the Disabled American Veterans in National Convention assembled in Atlanta, Georgia, August 16-20, 1987 support legislation to allow the VA and state and local government agencies to enter into agreements to place disabled veterans into an unpaid on-the-job/work experience program under Chapter 31, Title 38, U.S. Code.

* * *

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

July 11, 1988

Honorable Alan Cranston, Chairman
Committee on Veterans' Affairs
414 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Cranston:

As you are well aware, the Veterans Administration's Office of the Inspector General reported some very negative findings as a result of their audit of the Vocational Rehabilitation Program.

While we certainly agree the Vocational Rehabilitation Program needs scrutiny and improvement can be made we disagree with the obvious bias reflected in the IG report, i.e. they did not report one successful case yet, **several very negative cases were highlighted.**

I am enclosing for your review and information an analysis done of the Vocational Rehabilitation and Counselling Program by the Portland VA Regional Office. A review of the Oregon analysis certainly allows us to conclude that the program is indeed very successful.

I am also enclosing some preliminary data provided to the Administrators' Advisory Committee on Rehabilitation at its recent meeting which further supports the DAV's contention that the program is much more successful than as described by the IG audit.

It is hoped that this information can be incorporated into the hearing record of June 16, 1988.

Thank you for your continued interest in the Vocational Rehabilitation Program.

Sincerely,

Ronald W Drach

RONALD W. DRACH
National Employment Director

RWD:qeb

Preliminary Study of 1987 VA Rehabilitations

The primary focus of this study was to identify and evaluate the pre and post vocational rehabiliation employment incomes of all disabled veterans rehabilitated in 1987. After looking at 2,407 disabled veterans employment earnings, it was determined that their annual employment earnings increased by 560%.

Population in Study

The disabled veteran population selected for study were all disabled veterans who received a rehabilitation declaration in 1987. The total number of disabled veterans rehabilitated in 1987 were 2,407. In order to capture the pre-rehabilitation income of the earliest enrollee, we had to go back to 1983.

Majority of Disabled Veterans Were Unemployed at time of Application

A review of the data on Table A indicates that 1,338 veterans reported no earnings (55.6%). Another 490 on (20.3%) had earnings reported as unknown. The total for both categories "Unknown and No Earnings" is 1,828 or 75.9%. The entry "unknown" indicates a procedural error and efforts are now being made to track down the proper data.

Disabled Veterans at or Below Poverty Level Prior to Rehabilitation

The number of disabled veterans reporting incomes below the poverty level was 1,952 or 81.1%. All unknowns are included in this poverty group because preliminary findings indicate that, for the most part, these are unemployed individuals. This is a rough figure, as estimating poverty levels by region and by different indexes from different agencies is a very complex process. It is fair to say that disabled veterans at entry into the VA vocational rehabilitation program were in severe financial distress. The average earnings of all disabled veterans prior to initiation of their vocational rehabilitation program was $2,687.53. All income levels were based on mid-point earnings. This was done to identify trends in employment earnings of disabled veterans.

A good measure of how well a vocational rehabilitation program serves persons with disabilities lies in the income level of the person at time of their rehabiliation. Much can be said for high quality psychological evaluations, functional assessments, counseling sessions, etc., but to the individual who is poor, the most important outcome of the program (the major reason he/she came in for help) is the pay check.

Average Annual Employment Income _After_ Completion of Vocational Rehabiliation Program

The estimated average annual employment income of disabled veterans after completion of their vocational rehabilitation program was $15,047.85. This is a increase of 560% in earnings over their pre-rehabilitation income. This is a conservative figure since 195 of the 2,407 rehabilitations had no reported income at closure. This figure is misleading as these disabled veterans did received training, were reported as employed, and a DOT Code were entered but the income was not recorded in the computer. Attempts are now under way to eliminate "unknown" entries and obtain hard data.

Cost Effectiveness

There are few State or Federal programs where a positive impact on State and Federal tax revenues is found. Disabled veterans increased their annual _state tax revenue_ from $375,550.00 to

$2,166,096.00 or a 577% increase. This same population of disabled veterans increased their annual Federal tax revenue contribution from $580,914.00 to $4,106,573.00 or a 707% increase. In the area of Social Security revenues, these veterans increased their average annual social security payment from $485,814.39 to $2,720,136.70 or a 560% increase. A disabled veterans social security payment is matched by the employer. The estimated combined payment of the disabled veteran and employer amounts to $5,440,272.00 paid to social security.

Conclusion

It is hard to put numbers on the successfulness of rehabilitation programs. One of the very hard facts we have is income of the disabled person in terms of dollars. Using this criteria, the VA vocational rehabilitation program is nothing but successful.

EXAMPLE OF QUESTIONNAIRE

VA Regional Office (28)
1220 SW Third Avenue
Portland, OR 97204

Name of Veteran:____________________ Date:________________

C#________________ Name of VRS____________________

VA VOCATIONAL REHABILITATION SERVICE DELIVERY
QUESTIONNAIRE

To help us provide the best possible service to veterans we are seeking your opinion on the service you received. Please complete the following questionnaire by circling the answer that comes closest to matching your feelings.

1. VA vocational rehabilitation benefit and job information given by your Vocational Rehabilitation Specialist during rehab. training.

[✓ Excellent] Good Fair Poor

---

2. Amount of problem-solving counseling provided during rehab. training by your Vocational Rehabilitation Specialist.

[✓ Excellent] Good Fair Poor

---

3. How would you rate your Vocational Rehabilitation Specialist's effectiveness in assisting you in completing training?

[✓ Very Effective] Generally Effective Somewhat Ineffective Very Ineffective

---

4. Do you feel you are better off now than when you began the vocational rehabilitation program?

Yes ✓ No ___

Additional comments on VA vocational rehabilitation service: This program has helped me feel priviledged and important. Before this action I didn't maintain a job, I felt under qualified and insecure. The help that I received through and and is of the best. Thank you for providing these services and giving me a chance.

H. GORDON CAMPBELL, Ph.D.
Vocational Rehabilitation and
Counseling Officer.

[illegible]
maintained on Personal Computer

VR&C REPORT OF CASES REHABILITATED - MARCH 1985 TO JUNE 1988
Date: June 6, 1988

Objective	Location	Prerhb. pay	Postrhb. pay	(rhb inc) EARNED/MO	(proj.) TAX/MO	(proj.) TAX $/YR	(proj.) EARNED/YR	Area % EARNED/YR
Counselor	ALASKA	0.00	3000.00	3000.00	600.00	7200.00	36000.00	2.41
Metalurgy	ALBNY	0.00	1400.00	1400.00	280.00	3360.00	16800.00	
Administrative Asst.	ALBNY	750.00	1800.00	1050.00	210.00	2520.00	12600.00	
Ar Cndtng/Htng Rpr	ALBY	0.00	0.00	0.00	0.00	0.00	0.00	
Elctrn Tech	ALBY	0.00	1300.00	1300.00	260.00	3120.00	15600.00	
Elctrn Tech	ALBY	0.00	1800.00	1600.00	360.00	4320.00	21600.00	
Cosmetologist	ALBY	130.00	300.00	170.00	34.00	408.00	2040.00	
Wastewater Treatmnt	ALBY	0.00	1700.00	1700.00	340.00	4080.00	20400.00	
Photo-Jrnlst	ALBY			0.00	0.30	0.00	0.00	5.75
Cmptr Oprtr	AZ	0.00	1500.00	1500.00	300.00	3600.00	18000.00	1.20
Auto Mechanic	CA	0.00	2000.00	2000.00	400.00	4800.00	24000.00	1.60
Helcptr Mech	CO	1000.00	1500.00	500.00	100.00	1200.00	6000.00	0.40
Mechanical Engineer	CORVL	0.00	2000.00	2000.00	400.00	4800.00	24000.00	
Truck Driver	CRVLS	0.00	1600.00	1600.00	320.00	3840.00	19200.00	2.89
Jeweler	CSBAY	0.00	1032.00	1032.00	206.40	2476.80	12384.00	0.83
Saddle Maker	ED	1400.00	1800.00	400.00	80.00	960.00	4800.00	
Admin Asst	EG	0.00	940.00	940.00	188.00	2256.00	11280.00	
Auto Mech	ED	0.00	1000.00	1000.00	200.00	2400.00	12000.00	
Data Prcsng Sp	ED	0.00	200.00	200.00	40.00	480.00	2400.00	
Agri-Bus Agnt	ED	0.00	1000.00	1000.00	200.00	2400.00	12000.00	
Farmer	ED	0.00	1000.00	1000.00	200.00	2400.00	12000.00	3.64
Truck Driver	EUG	0.00	1515.00	1515.00	303.00	3636.00	18180.00	
Diesel Engr Tech	EUGENE	860.00	2167.00	1307.00	261.40	3136.80	15684.00	
Radiological Tech	EUGENE	600.00	1634.00	1034.00	206.80	2481.60	12408.00	
Cmptr Progrmr	EUGN	520.00	1720.00	1200.00	240.00	2880.00	14400.00	
Electronic Technician	EUGN	0.00	1465.00	1465.00	293.00	3516.00	17580.00	
Auto Mech	EUGN	0.00	1214.00	1214.00	242.80	2913.60	14568.00	
Envrmentl Anlyst	EUGN	0.00	1200.00	1200.00	240.00	2880.00	14400.00	
Auto Mech.	EUGN	0.00	1204.00	1204.00	240.80	2889.60	14448.00	
Food Svc Supr	EUGN	780.00	688.00	688.00	137.60	1651.20	8256.00	
Radio Brdcstr	EUGN	0.00	700.00	700.00	140.00	1680.00	8400.00	
Electronic Tech	EUGN	0.00	863.00	863.00	172.60	2071.20	10356.00	
Casewrkr	EUGN	0.00	600.00	600.00	120.00	1440.00	7200.00	
Real Est Brkr	EUGN	0.00	1250.00	1250.00	250.00	3000.00	15000.00	
Polcy Analst	EUGN	0.00	1040.00	1040.00	208.00	2496.00	12480.00	
Sewng Mach Repr	EUGN	0.00	600.00	800.00	160.00	1920.00	9600.00	
Caseworker	EUGN	0.00	997.00	997.00	199.40	2392.80	11964.00	
Counseling	EUGN	0.00	1789.00	1789.00	357.80	4293.60	21468.00	
Public Agncy/Prgm Mgr	EUGN	0.00	2125.00	2125.00	425.00	5100.00	25500.00	
Auto-Desl Mech	EUGN	0.00	1892.00	1892.00	378.40	4540.80	22704.00	
Lbr Relations Mgr	EUGN	0.00	4100.00	4100.00	820.00	9840.00	49200.00	
Truck Driver	EUGN	0.00	1800.00	1800.00	360.00	4320.00	21600.00	
Wtr Treat Plt Opr	EUGN	0.00	1462.00	1462.00	292.40	3508.80	17544.00	
Pastor	EUGN	0.00	1240.00	1240.00	248.00	2976.00	14880.00	
Radio Newscaster	EUGN	0.00	860.00	860.00	172.00	2064.00	10320.00	
Cosmetlogst	EUGN	0.00	1000.00	1000.00	200.00	2400.00	12000.00	26.75
Real Estate Sales	FLOR	325.00	1000.00	675.00	135.00	1620.00	8100.00	9.54
Auto Body	HLSB	0.00	1600.00	1600.00	320.00	3840.00	19200.00	1.28
Elec Engr	ID	800.00	2000.00	1200.00	240.00	2880.00	14400.00	0.96
Computer Technician	KFALLS	0.00	2100.00	2100.00	420.00	5040.00	25200.00	1.66
Respiratory therapist	MDFRD	520.00	1249.00	729.00	145.80	1749.60	8748.00	
Fine Artist	MEDFORD	0.00	200.00	200.00	40.00	480.00	2400.00	[illegible]
Contract Rep (agency)	MICH	[illegible]	1200.00	1200.00	[illegible]	[illegible]	[illegible]	[illegible]

Optical Tech	MONTANA	0.00	1500.00	1500.00	300.00	3600.00	18000.00	1.20
Cosmotligst	PTLD			0.00	0.00	0.00	0.00	
Electnc Tech	PTLD	0.00	1000.00	1000.00	200.00	2400.00	12000.00	
Powerplnt Mecn	PTLD	0.00	1473.00	1473.00	294.60	3535.20	17676.00	
Elctrnc Tech	PTLD	0.00	1300.00	1300.00	260.00	3120.00	15600.00	
Truck Drvr	FTLD	0.00	1200.00	1200.00	240.00	2880.00	14400.00	
Prchsng Agnt	PTLD	0.00	900.00	900.00	180.00	2160.00	10800.00	
Electnc Tech	FTLD	0.00	1100.00	1100.00	220.00	2640.00	13200.00	
Auto Tech	FTLD	0.00	600.00	600.00	120.00	1440.00	7200.00	
Small Engine Repair	PTLD	0.00	1360.00	1360.00	272.00	3264.00	16320.00	
Business Programmer	PTLD	0.00	953.00	953.00	190.60	2287.20	11436.00	
Aucit Acct Aide-Revenu	FTLD	0.00	1200.00	1200.00	240.00	2880.00	14400.00	
Arch Draftng	PTLD	0.00	800.00	800.00	160.00	1920.00	9600.00	
Prgrmmer	PTLD	0.00	1400.00	1400.00	280.00	3360.00	16800.00	
Appliance Service	FTLD	1000.00	1075.00	75.00	15.00	180.00	900.00	
Const. Tech	FTLD			0.00	0.00	0.00	0.00	
Tech Drctor	FTLD	0.00	1380.00	1380.00	276.00	3312.00	16560.00	
Barber	FTLD	0.00	1500.00	1500.00	300.00	3600.00	18000.00	
Safety Engr	FTLD			0.00	0.00	0.00	0.00	
Robotics Tech	FTLD	1600.00	1833.00	233.00	46.60	559.20	2796.00	
Comptr Oprtr	FTLD	0.00	1600.00	1600.00	320.00	3840.00	19200.00	
Electronics Tech	FTLD	0.00	800.00	800.00	160.00	1920.00	9600.00	
Refrig. Tech.	FTLD			0.00	0.00	0.00	0.00	
Mngmt Trnee	FTLD	0.00	1483.00	1483.00	296.60	3559.20	17796.00	
Jeweler Apprentice	FTLD	0.00	860.00	860.00	172.00	2064.00	10320.00	
Heavy Duty Truck Drvr	FTLD	0.00	1892.00	1892.00	378.40	4540.80	22704.00	
Electn Engnr	FTLD	900.00	1300.00	400.00	80.00	960.00	4800.00	
Upholsterer	PTLD	500.00	989.00	489.00	97.80	1173.60	5868.00	
Arch Drafting	FTLD	0.00	1560.00	1560.00	312.00	3744.00	18720.00	
Teacher	FTLD	0.00	1700.00	1700.00	340.00	4080.00	20400.00	
Admin Asst.	FTLD	0.00	1000.00	1000.00	200.00	2400.00	12000.00	
Heavy Trk Drvr	FTLD	0.00	1800.00	1800.00	360.00	4320.00	21600.00	
Ag. Mech.	FTLD	0.00	1500.00	1500.00	300.00	3600.00	18000.00	
Sales Manager	FTLD	0.00	1800.00	1800.00	360.00	4320.00	21600.00	
Accountnt	FTLD	0.00	1612.00	1612.00	322.40	3868.80	19344.00	
Saddlemaker	FTLD	0.00	1000.00	1000.00	200.00	2400.00	12000.00	
Social Worker	FTLD	0.00	1075.00	1075.00	215.00	2580.00	12900.00	
Electronic Eng.	FTLD	0.00	1100.00	1100.00	220.00	2640.00	13200.00	
Electrn Tech	FTLD	400.00	1324.00	924.00	184.80	2217.60	11088.00	
Truck Driver	FTLD	0.00	2000.00	2000.00	400.00	4800.00	24000.00	
Printer	FTLD			0.00	0.00	0.00	0.00	
Electronic Tech	FTLD	[illegible]	[illegible]	1500.00	300.00	3600.00	18000.00	
Mgmt Trainee	FTLD			0.00	0.00	0.00	0.00	
Mgr Trainee	FTLD			0.00	0.00	0.00	0.00	
Regstrd Nurse	FTLD			0.00	0.00	0.00	0.00	
Mgr Indust Drftn	FTLD	[illegible]	1817.00	1817.00	363.40	4360.80	21804.00	
Electrn Tech	FTLD	[illegible]	[illegible]	200.00	40.00	480.00	2400.00	
Diesel Mech.	FTLD	0.00	1400.00	1400.00	280.00	3360.00	16800.00	
Pharmacist	FTLD	0.00	2000.00	2000.00	400.00	4800.00	24000.00	
Electronic Tech	FTLD			0.00	0.00	0.00	0.00	[illegible]
Electronics Tech.	SALEM	0.00	1200.00	1200.00	240.00	2880.00	14400.00	
Visual Arts Publicn.	SALM	[illegible]	750.00	750.00	150.00	1800.00	9000.00	
Termnl Systm Oprtr	SALM			0.00	0.00	0.00	0.00	
Auto Diesel Mech.	SALM			0.00	0.00	0.00	0.00	
Forester	SALM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Auto Mechanic	SALM		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

Auto Mech	SALM	953.00	1032.00	79.00	15.80	189.60	948.00	
Asbestos Wrker	SALM	0.00	2494.00	2494.00	498.80	5985.60	29928.00	
Sal Engn Rprman	SALM			0.00	0.00	0.00	0.00	
Electronic Service	SALM	0.00	1800.00	1800.00	360.00	4320.00	21600.00	6.52
Gunsmith	SWT.HOME	0.00	1800.00	1800.00	360.00	4320.00	21600.00	1.44
Station Manager	TLMK	1000.00	1400.00	400.00	80.00	960.00	4800.00	0.32
Aviation Maint. Tecn.	VANC	800.00	1000.00	200.00	40.00	480.00	2400.00	0.16
		16288.00	140938.00	124650.00	24930.00	299160.00	1495800.00	100.00

VOCATIONAL REHABILITATION AND COUNSELING PROGRAM
PORTLAND VA REGIONAL OFFICE

DIRECTOR'S PUBLIC RELATIONS ANALYSIS

Over the years, the Portland VA Regional Office has provided resources and guidance to service-disabled veterans as they seek maximum independence and self-sufficiency through vocational rehabilitation and employment. Work measurement and quality reviews have consistently shown that Dr. Gordon Campbell and his staff have been doing an outstanding job in this regard. However, for some time we've wanted a more "down-to-earth" measure of our success in this program. As a result, we have developed a three-point plan which serves as an excellent vehicle in conveying to veterans organizations, congressional staffs and the general public the effectiveness of VA vocational rehabilitation programs. This plan is illustrated in the following three steps.

1. VA Vocational Rehabilitation Service Delivery Questionnaire.

Recognizing that "perception" is often keyed to subjective feelings rather than objective results, our questionnaire (test initiative) asks four general questions about a client's experience with the program. Responses can range from "Excellent" or "Very Effective" to "Poor" or "Very Ineffective." There is also a space for additional comments. For the most part, in our public relations efforts, we focus on the following question. "Do you feel you are better off now than when you began the vocational rehabilitation program?" Ninety-seven percent of all respondents have answered yes to this question!

2. Comparative analysis of veterans earnings status prior to beginning rehabilitation versus post-rehabilitation.

In addition to a subjective response that clients are "better off," we have established conclusive evidence of that fact by tracking each client's earnings status. In summary, our findings show that veterans completing VA vocational rehabilitation programs in Oregon over the last three years have increased their collective gross take-home pay by $1.5 million. In addition to the obvious personal boost given to veterans who become self-sufficient, there are ancillary benefits to the state economy and even to taxing authorities. One pragmatic viewpoint is that veterans who could have been long-term tax liabilities for federal, state and local programs become tax revenue producers -- a status which they much prefer.

3. Successful Examples.

Subjective opinions and overall statistical analyses only point to the general success of the program. Some individual success stories are as follows:

> Albany, Oregon - a veteran who had no employment prior to rehabilitation. He now works as an Electronics Technician with a gross annual salary of $21,600.

> Eugene, Oregon - a veteran who had no employment prior to rehabilitation. He now works as an Auto-Diesel Mechanic with a gross annual salary of $22,700.
>
> Portland, Oregon - a veteran who had no employment prior to rehabilitation. He now works as a school teacher with a gross annual salary of $20,400.

In addition to the above information, we have taken a particular interest in efforts to assist veterans rated for the service-connected disability of Post-Traumatic Stress Syndrome (PTSD). Currently an estimated 30% of our active trainees are rated for this condition. Two successful examples stand out.

> One Chapter 31 graduate of a major Oregon University studied in the field of vocational rehabilitation. He is now working for the VA at a Vet Counseling Center where he assists other veterans who also suffer PTSD.
>
> Another PTSD-rated veteran who attained a bachelor's degree under the Chapter 31 program works for the State of Oregon Employment Division where he assists other veterans in obtaining employment.

We emphasize the PTSD ratio of trainees and their success stories in an effort to encourage more such veterans, many of whom are initially reluctant to seek help from the VA.

Our overall conclusion is this -- not all veterans who are eligible for vocational rehabilitation will accept our offer of assistance. Not all veterans who enter the program will be successful in gaining more income and better jobs. However, this in no way detracts from the vast majority represented by the above-noted results we have identified through surveys, analyses and personal success stories.

June 1988

JGM:lj

Prepared by: Dr. William Eddy (222A)
Personnel Development and Special Projects
VR&E Service, Department of Veterans Benefits

TABLE A

Preliminary Study of 1987 Rehabilitations

Estimated Monthly Employment Income of Disabled Veteran Participants in the Veterans Administration Vocational Rehabilitation Program

MONTHLY PRE-REHAB SALARY	FREQUENCY (FX)	PERCENT	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT	MID POINT INCOME (MPI)	ESTIMATED ANNUAL INDIVIDUAL AVERAGE INCOME	ESTIMATED ANNUAL INDIVIDUAL AVERAGE INCOME X FREQUENCY (FX)	ESTIMATED ANNUAL AVERAGE TAX	FX x ESTIMATED AVERAGE TAX
UNKNOWN	490	20.3	490	20.3	0.00	0.00	0.00	0.00	0.00
NO EARNINGS	1338	55.6	1828	75.9	0.00	0.00	0.00	0.00	0.00
$80 - $124.00	2	0.1	1830	76.0	102.00	1,224.00	2,448.00	0.00	0.00
$125 - $149.00	8	0.3	1838	76.4	137.00	1,644.00	13,152.00	0.00	0.00
$150 - $199.00	1	0.0	1839	76.4	175.00	2,100.00	2,100.00	0.00	0.00
$200 - $299.00	29	1.2	1868	77.6	250.00	3,000.00	87,000.00	0.00	0.00
$300 - $399.00	25	1.0	1893	78.6	350.00	4,200.00	105,000.00	0.00	0.00
$400 - $499.00	59	2.5	1952	81.1	450.00	5,400.00	318,600.00	106.00	6,254.00
$500 - $599.00	45	1.9	1997	83.0	550.00	6,600.00	297,000.00	172.00	7,740.00
$600 - $699.00	67	2.8	2064	85.7	650.00	7,800.00	522,600.00	434.00	29,078.00
$700 - $799.00	29	1.2	2093	87.0	750.00	9,000.00	261,000.00	614.00	17,806.00
$800 - $899.00	66	2.7	2159	89.7	850.00	10,200.00	673,200.00	794.00	52,404.00
$900 - $999.00	27	1.1	2186	90.8	950.00	11,400.00	307,800.00	974.00	26,298.00
$1000 - $1499.00	155	6.4	2341	97.3	1,250.00	15,000.00	2,325,000.00	1,514.00	234,670.00
$1500 - $1999.00	46	1.9	2387	99.2	1,750.00	21,000.00	966,000.00	2,414.00	111,044.00
$2000 - $2499.00	12	0.5	2399	99.7	2,250.00	27,000.00	324,000.00	4,065.00	48,780.00
$2500 - $2999.00	8	0.3	2407	100.0	2,750.00	33,000.00	264,000.00	5,855.00	46,840.00
$3000 AND ABOVE	0	0.0		00.0	0.00		0.00	0.00	0.00
							6,468,900.00		580,914.00

1. Total monthly pre-rehabilitation income for all disabled veterans = $539,075.00

2. Total annual pre-rehabilitation income for all disabled veterans = $6,468,900.00

3. Average pre-rehabilitation earnings of all disabled veterans prior to initiation of vocational rehabilitation program [$6,468,900.00 (annual income for all veterans) divided by 2,407 (total number of veterans in study)] = $2,687.53

4. Estimated average pre-rehabilitation annual tax revenue generated (Federal) = $580,914.00

5. Estimated average pre-rehabilitation annual revenue generated (State) at 6% of $6,259,200.00 income at taxable level of income = $375,552.00

6. Estimated pre-rehabilitation social security paid by disabled veterans at 7.51% of $6,468,900.00 = $485,814.39

TABLE B

Estimated Monthly Income Reported for Veterans Rehabilitated in 1987

MONTHLY POST-REHAB ~~SALARY~~	FREQUENCY (FX)	PERCENT	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT	MID POINT INCOME (MPI)	(FX x MPI)	ESTIMATED ANNUAL INDIVIDUAL AVERAGE INCOME	ESTIMATED ANNUAL INDIVIDUAL AVERAGE TAX INCOME X FREQUENCY (FX)	ESTIMATED ANNUAL AVERAGE	FX x ESTIMATED AVERAGE TAX (5)
*UNKNOWN	87	3.6	87	3.6	0.00	0.00	0.00	0.00	0.00	0.00
+NO EARNINGS	108	4.5	195	8.1	0.00	0.00	0.00	0.00	0.00	0.00
LESS THAN $40.00	4	0.2	199	8.3	20.00	80.00	240.00	960.00	0.00	0.00
$40 - $79.00	2	0.1	201	8.4	60.00	120.00	720.00	1,440.00	0.00	0.00
$80 - $124.00	4	0.2	205	8.6	102.00	408.00	1,224.00	4,896.00	0.00	0.00
$150 - $199.00	1	0.2	206	8.8	175.00	175.00	2,100.00	2,100.00	0.00	0.00
$200 - $299.00	14	0.5	220	9.3	250.00	3,750.00	3,000.00	42,000.00	0.00	0.00
$300 - $399.00	16	0.7	236	10.0	350.00	5,600.00	4,200.00	67,200.00	0.00	0.00
$400 - $499.00	23	1.0	259	11.1	450.00	10,300.00	5,400.00	124,200.00	106.00	2,438.00
$500 - $599.00	45	1.9	304	12.9	550.00	24,750.00	6,600.00	297,000.00	252.00	11,340.00
$600 - $699.00	82	3.4	386	16.3	650.00	53,300.00	7,800.00	639,600.00	434.00	35,588.00
$700 - $799.00	74	3.1	460	19.4	750.00	55,500.00	9,000.00	666,000.00	614.00	45,436.00
$800 - $899.00	155	6.4	615	25.8	850.00	131,750.00	10,200.00	1,550,000.00	794.00	123,070.00
$900 - $999.00	147	6.1	762	31.9	950.00	139,650.00	11,400.00	1,675,800.00	974.00	143,178.00
$1000 - $1499.00	907	37.6	1669	69.5	1,250.00	1,133,750.00	15,000.00	13,605,000.00	1,514.00	1,373,198.00
$1500 - $1999.00	508	21.0	2177	90.5	1,750.00	889,900.00	21,000.00	10,668,000.00	2,414.00	1,226,312.00
$2000 - $2499.00	160	6.6	2337	97.1	2,250.00	360,000.00	27,000.00	4,320,000.00	4,065.00	650,400.00
$2500 - $2999.00	52	2.2	2389	99.3	2,750.00	143,000.00	33,000.00	1,716,000.00	5,855.00	304,460.00
$3000 - $3999.00	13	0.5	2402	99.8	3,500.00	45,000.00	42,000.00	546,000.00	9,005.00	117,065.00
$4000 - $4999.00	3	0.1	2405	99.9	4,500.00	13,500.00	54,000.00	162,000.00	13,205.00	39,615.00
$5000 - AND ABOVE	2	0.1	2407	100.0	5,500.00	11,000.00	66,000.00	132,000.00	17,736.00	34,473.00
								36,220,196.00		4,106,573.00

1. Total monthly post-rehabilitation employment income for all disabled veterans at rehabilitation = $3,021,533.00 .

2. Annual post-rehabilitation income generated through employment = $36,220,196.00

3. Average annual employment income *after* completion of vocational rehabilitation program = $15,047.85

4. Increase post-rehabilitation in employment earnings = 560%

5. Estimated post-rehabilitation average annual Federal tax revenue generated = $4,106,573.00

6. Percentage increase in Federal tax revenue from employment compared to pre-rehab data = 707%

7. Estimated annual State tax revenue generated by disabled veterans at 6% is a result of VA vocational rehabilitation program. [$36,101,600.00 (taxable level income) times .06%] = $2,166,096.00

8. Estimated social security paid by disabled veterans after completion of vocational rehabilitation program. [$36,220,196.00 (annual income for all veterans) times .0751 (factor to determine level of social security payment)] = $2,720,136.70

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*Employment earnings for 195 veterans unreported at time of study. For the most part, this is assumed to be due to procedural error. Efforts are being made to correct this problem and update the master record in June. Of those who were rehabilitated, nineteen were severely disabled veterans who received independent living services. (Employment and income were not the goals of the services provided)

+Significant numbers, now being studied, are retired or seriously disabled working in parttime employment.

Significant Indicators Relating to the Effect of the VA's Vocational Rehabilitation Program on Disabled Veterans Rehabilitated in 1987

*Annual reported earnings of disabled veterans and income growth indicators are summarized below. The selected indicators reflect the effectiveness of the VA vocational rehabilitation program.

1. Total annual employment income for all disabled veterans prior to rehabilitation (2,407 participants):	$6,468,900.00
2. Total annual employment income reported for same disabled veterans subsequently rehabilitated in 1987 (2,407 participants):	$36,220,196.00
3. Total increase of average annual employment income of 2407 participants after completion of rehabilitation:	$29,751,296.00
4. Percent increase in employment earnings as a result of VA's vocational rehabilitation program:	
[$36,220,196.00 [Total annual employment income generated for all disabled veterans rehabilitated in 1987] divided by $6,468,900.00 [Total income for all disabled veterans at the time they applied for the VA vocational rehabilitation program]:	560%
5. Average Annual income per disabled veterans grew from $2,687.53 to $15,047.85, an increase of:	$12,360.32
6. Total estimated average annual federal tax revenue prior to VA vocational rehabilitation program:	$580,914.00
7. Total estimated average annual federal tax revenue after VA vocational rehabilitation program:	$4,106,573.00
8. Percent increase of average annual federal tax revenue as a result of VA vocational rehabilitation program (Federal):	707%
9. Total estimated average annual state tax revenue prior to VA vocational rehabilitation program:	$375,552.00
10. Total estimated average annual state tax revenue after VA vocational rehabilitation program (State):	$2,166,096.00
11. Percent increase in average annual state tax revenue as a result of VA vocational rehabilitation program	577%
12. Total estimated average annual social security paid by disabled veterans prior to VA vocational rehabilitation program	$485,814.39
13. Total estimated average annual social security paid by disabled veterans after VA vocational rehabilitation program	$2,720,136.70
14. Percent increase in average social security paid as a result of VA vocational rehabilitation program	560%

*Adjustments related to inflation were not made because of the five year period covered; multi entry and exit dates (2,407), and because this is a preliminary analysis.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
WITH RESPECT TO

VARIOUS LEGISLATIVE PROPOSALS

WASHINGTON, D. C. JUNE 16, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to the oversight of the Veterans Administration's program of training and rehabilitation for veterans with service-connected disabilities and several bills impacting on VA program issues. The VFW is appreciative of this distinguished Committee for holding this hearing, demonstrating its continuing concern for our nation's veterans.

S. 2294, introduced by Senator Cranston at the request of the Veterans Administration, would extend the VA's authority to continue major health-care programs, revise and clarify VA authority to furnish certain health-care benefits and to enhance the VA's authority to recruit and retain certain health-care personnel.

Section 2 of this bill would provide ongoing authority for the VA to contract for care, treatment and rehabilitative services in halfway houses,

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VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202-543-2239

therapeutic communities, psychiatric residential treatment centers and other community-based treatment centers for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. The VFW, in testimony before this Committee last week, recommended this vital program be made permanent and we certainly welcome this provision of S. 2294.

Section 3 would extend for two years the VA's authority to provide respite care services. The VFW fully supports this program and certainly supports its extension. We would prefer to see the respite care program made permanent.

Section 4 would clarify that the VA has the authority to pay for emergency medical services for veterans participating in a vocational rehabilitation program under chapter 31, 38 USC, when the veteran cannot reasonably obtain medical care through the VA or other government facilities. Currently, the VA will generally pay for care of veterans in private facilities only when the care has been authorized in advance. An exception does exist for some vetearns who participate in a vocational rehabilitation program; but, unfortunately, not all. Section 4 addresses this shortcoming and has the support of the VFW.

Section 5 would extend through September 30, 1994, the authority of the Administrator to contract with the Veterans Memorial Medical Center in the Philippines to provide for payments for care of eligible United States veterans. The VFW supports this extension so the United States may fulfill its longstanding moral obligations to Filipino veterans who served in components of the United States armed services. This section would also extend through 1994 the authority to make annual grants to the VMMC for the replacement and upgrading of equipment and modernization of facilities. We also support the provisions of this section.

With respect to recruitment and retention of VA health-care personnel, S. 2294 would make the Veterans Administration Health Professional Scholarship

Program more flexible by authorizinig scholarships in any field of training or study in direct health-care services. Currently, scholarships have been awarded only to nursing students. The bill would also authorize the VA to reimburse nurses for tuition expenses incurred in pursuing professional courses leading to a degree in nursing. The VFW believes these provisions will enhance the VA's ability to attract and retain health-care personnel and, therefore, supports their enactment.

S. 2293, introduced by the Chairman of this Committee at the request of the Veterans Administration, would raise the Veterans Administration's minor construction cost limitation from $2 million to $3 million. It is our understanding this increase is necessary due to inflation. The VFW has no objection to the enactment of this bill.

S. 2459, introduced by Mr. Rockefeller, Mr. Cranston and Mr. Murkowski, would extend for one year the temporary program of vocational training for certain veterans who are awarded a pension and whom the Administrator determines have a reasonable chance of attaining a vocational goal. The VFW supported the implementation of this program and we support this one-year extension.

S. 2446, introduced by Mr. Rockefeller and the Chairman of this Committee, would extend for one year the authorization of the Veterans Administration to furnish respite care to chronically ill veterans. As stated previously, the VFW strongly supports the concept of respite care and we certainly support the program's extension. Again, we would suggest to the Committee our recommendation to make this program permanent in light of its overwhelming success and benefit to veterans and their families.

S. 2396, introduced by Mr. Mitchell and the Chairman of this Committee, would expand the period considered as the Vietnam Era. The present starting date--August 5, 1964--coincides with the Gulf of Tonkin incident where North Vietnamese gunboats attacked two United States Navy destroyers. S, 2395 would set the date at February 28, 1961. While the VFW does not oppose this expansion, the voting delegates to our most recent National Convention adopted a resolution urging Congress to set a date of July 1, 58. We believe this date is more appropriate inasmuch as the United States has recognized our involvement in Vietnam by awarding the Armed Forces Expeditionary Medal and the Navy and Marine Corps Expeditionary Medal for service in Vietnam for the period of July 1, 1958 to July 3, 1965.

S. 2207, introduced by Senator Murkowski, the ranking minority member of this Committee, would authorize the Administrator of Veterans Affairs to provide assistive simians and dogs to veterans who, by reason of quadriplegia, are entitled to disability compensation. Although the VFW does not have a specific resolution addressing this proposal, we believe this bill could be of great benefit to this nation's quadriplegic veterans and, therefore, we support its enactment.

S. 2464, introduced by the Chairman of this Committee at the request of the Veterans Administration, would provide authority for the payment of interest on insurance settlements and to permit increased discount rates for insurance premiums paid in advance.

Section 101 and 102 of S. 2464 would authorize the Administrator to pay interest on policy proceeds from National Service Life Insurance, Veterans' Special Life Insurance, Veterans' Re-opened Insurance, and United States Government Life Insurance from the date of death to the date of payment. Although claims are generally paid within 10 days from the date of receipt in the

VA, in some cases a significant period of time can elapse between the date when life insurance proceeds become payable and the date when the actual payment is made.

Section 201 would authorize the Administrator to adjust the discount rates for premiums paid in advance on NSLI, VSLI and VRI policies. Currently, the discount rates are set with no provision for variance. By allowing a greater discount, veterans would enjoy lower premiums when paying on a quarterly, semi-annual or annual basis. The VFW has no objection to the enactment of this bill.

S. 2394, introduced by Senator Cranston at the request of the Veterans Administration, would authorize the appointment of Veterans Administration trained graduates in certain health-care professions or occupations by the Veterans Administration without regard to civil service hiring procedures. This authority would be limited only to those graduates who served under an appointment in a VA health-care facility in a clinical education program which was affiliated with an accredited college or university. Again, the VFW views this action as an enhancement to the VA's recruitment program and, therefore, supports its passage.

S. 2463, introduced by the Chairman and several members of this Committee, would improve the capability of the VA health-care facilities to provide the most effective and appropriate services possible to veterans suffering from mental illness, especially conditions which are service related. Specifically, the bill would authorize the establishment of five mental illness research, education, and clinical centers (MIRECCs). The MIRECCs would be patterned after the VA's Geriatric Research, Education and Clinical Centers (GRECCs) program. Each MIRECC would concentrate on one or more of the major categories of illnesses for which veterans suffer. These illnesses would include, but not be limited to, schizophrenia, PTSD, addictive disorders, depressive neuroses or dementias.

The VFW commends Senator Cranston and the cosponsors of S. 2463 for introducing this much-needed and crucial legislation. Much more needs to be learned about the devastations of mental illness and the possible ways to treat and cure it. In supporting this legislation, the VFW would urge this Committee and the entire Congress that if this bill were to be enacted enacted that adequate funding be appropriated to ensure its success. As you know, 25 GRECCs have been authorized by the Congress but only 12 are operational. The VFW has been very supportive of the GRECC program as we see it playing a crucial role in caring for the aging veteran. We see an equally important role for the MIRECCs and urge its implementation.

S. 2462, introduced by the Chairman and several members of the Committee, would improve various aspects of the Veterans Administration's health-care program, provide certain new categories of veterans with eligibility for readjustment counseling, extend the authorization of appropriations for certain grant programs, and revise certain provisions relating to the personnel system of the Department of Medicine and Surgery.

One provision would extend entitlement for readjustment counseling to veterans who have served in hostilities after May 7, 1975. This provision would recognize those members of the armed forces who are exposed at times to combat situatiuons even though war has not been declared. Examples of such cases are Beruit, Grenada and our efforts in the Persian Gulf.

The bill would also require the Director of the Office of Personnel Management within 45 days of receipt to concur with or disapprove VA proposals for special rate authorization for title 5 employees employed at VA health-care facilities. We view this provision as an action which would improve timeliness in obtaining or retaining critical title 5 employees.

S. 2462 also addresses problems relating to the VA's personnel system as it pertains to VA health-care employees--principally physicians, dentists and nurses--who are employed under title 38. S. 2462 improves the system by utilizing title 5 grievance procedures when addressing lesser disciplinary actions involving title 38 employees. We view this as a step to ensure fairness and, in general, a conforming amendment.

S. 2462 would authorize the Administrator to enter into agreement for the purpose of sharing scarce medical resources. Under current law, the Administrator may only enter into sharing agreements with other hospitals. This provision would grant the Administrator more flexibility in obtaining and providing medical resources to better serve the veteran.

Another provision would authorize the VA Administrator to carry out a program of grants to provide assistance in the establishment of cooperative arrangements among universities, colleges and other post-secondary schools affiliated with the VA. Again, this provision will enhance the VA's ability to recruit health-care personnel in a time when critical shortages are being experienced.

Finally, the bill would require the Chief Medical Director to conduct a pilot program to determine the desirability of implementing various pay and management practices relating to the recruitment and retention of registered nurses and other scarce health-care professionals. Specifically, this provision would expand the administrative and supervisory responsibilities of Chiefs of Nursing Services to include support services and clinical departments other than nursing, explore new alternatives for utilizing the skills and knowledge of registered nurses in furnishing direct-patient care, and increase evening and night shift pay differentials.

The VFW supports the enactment of S. 2462.

S. 2419 would repeal provisions relating to setting the interest rate on guaranteed or insured housing loans to veterans and inspecting manufactured homes purchased by veterans. The bill would also modify the procedures for the sale of loans by the VA.

With respect to section 2, the Veterans of Foreign Wars strongly opposes eliminating the Administrator of Veterans Affairs current authority to establish the VA home loan interest rate. We view the often posited argument that this authority limits a veteran's ability to negotiate a more favorable rate as specious. The VA established rate is, in fact, only a ceiling which certainly does not disallow a veteran and a lending institution from negotiating a lower mortgage rate. The VA established rate not only provides the veteran with greater parity in an unequal market place, it also serves as a national benchmark providing both the mortgage and the building industries with a degree of stability that they would not otherwise enjoy. We are convinced that eliminating the Administrator's authority to establish an interest ceiling would be a serious mistake, working against the veteran's best interest and seriously jeopardizing a most beneficial program.

This bill also provides that the Administrator may sell a vendee loan with recourse, or without recourse. The VFW continues to strongly support the VA selling its vendee loans without recourse since this minimizes the program's financial exposure. However, we also recognize that loans sold without recourse do not command as much money as those sold with recourse and that this can result in the VA home loan program losing money. This is especially true if, say, OMB were to force the VA to sell off a large portion of its vendee loans without recourse at a drastically discounted rate in order to realize a large, one-shot infusion of deficit reducing revenue. Needless to say, though, this would have a very harmful consequence for the long-term functioning of the program.

Section 4 would repeal certain requirements of the VA manufactured home loan program. We certainly believe the manufactured home has a place in the VA home loan program. However, due to scandals that have plagued the industry, we are hesitant in supporting this provision of the bill which would eliminate VA control through oversight. Our primary concern is for the protection of the veteran. Until the industry, States and local government exhibit more stringent controls, we favor continued VA involvement. It is for these reasons that we support the amendment under this section which would add as a basis for a manufacturer's suspension from the program for engaging in actions unfair or prejudicial to veterans or the government.

Section 5 would repeal the requirement for a statement of local officials regarading the feasibility of public or community water and sewage systems as a condition to the VA guaranty of newly constructed homes. While this certification may place some burden on local officials and program participants, we do believe the veteran is benefited from this requirement.

Section 6 would expand the VA's authority to collect housing loan debts by offsetting a debtor's federal tax refund. We would have no objection to this provision as long as the VA makes every attempt to recover the debt through accepted channels.

Section 7 would impose a time limit during which a veteran may request a waiver of a loan guaranty debt. This is a conforming amendment inasmuch as all other VA requests for waivers of debt must comply to a time limitation. Section 7 also contains a technical amendment which provides that active duty service members are also eligible for waiver consideration. The VFW has no objection to this section of the bill.

Finally, Mr. Chairman, in your letter of invitation, we were asked to comment on the VA's administration of the Program of Training and Rehabilitation for veterans with service-connected disabilities under chapter 31, title 38.

As you know, Mr. Chairman, the VA has administered this Vocational Rehabilitation Program for a number of years. The enactment of Public Law 96-466 updated and expanded this program in ways that considerably enhanced the VA's ability to respond positively to the multitude of needs of disabled veterans. Briefly, the law provides that services and assistance necessary to enable service-connected disabled veterans to achieve maximum independence in daily living and, to the maximum extent possible, to become employable and obtain and maintain suitable long-term employment be carried out through a number of means. Among these are: evaluation (or reevaluation) of a veteran's potential for rehabilitation; educational, vocational, psychological, employment and personal adjustment counseling; a work-study allowance; employment placement services; personal and work adjustment training; various training services and assistance, including tuition, fees, books, supplies, equipment and other training materials; interest-free loans; prosthetic appliances, eyeglasses and other corrective and assistive devices; services to a veteran's family to facilitate the veteran's effective rehabilitation; service supplies and equipment for homebound training or self-employment; travel and incidental expenses for job seeking; services necessary to enable a veteran to achieve maximum independence in daily living, and others.

According to a VFW survey, our Department Service Officers are virtually unanimous in agreeing that the program is working well. In the survey many commented that DVB is bending over backward to accommodate veterans. Further, it was reported that many stations were aggressively conducting vocational rehabilitation outreach; however, there is concern that older veterans are perhaps being overlooked. We do, furthermore, recognize other problem areas.

There is unanimity in the assessment that the greatest single problem facing the VA Vocational Rehabilitation Program is a shortage of staff. It has been noted by our Department Service Officers that delayed rating/application decisions cause veterans to miss course and program opening dates. There have been reports of lengthy approval times due to delays getting the application through adjudication. Furthermore, counseling is often not available on a timely bases in certain areas due to staff shortages. Thus, the majority of the problems we have found with the program lie not with the involved staff, but rather with their lack of numbers. Staffing should be increased.

A major concern that has come out of the aforementioned VFW survey on this issue is the situation where a veteran is judged by a vocational rehabilitation counselor as not being suited for the program due to service-connected disabilities then upon application for an increase in compensation is denied on the grounds that the involved veteran can indeed work. We very strongly believe that this misunderstanding and confusion with respect to the criteria for rating a disability must be rectified.

Even so, the VA's Vocational Rehabilitation Program has, in our view, been well managed and has accomplished much toward assisting service-connected disabled veterans lead meaningful and productive lives. We have found VA personnel extremely competent in the counseling and psychological aspects of the program. But the handling of the multiplicity of employment-related aspects of the program, as called for in the provisions of Public Law 96-466, could well stand some fine tuning.

As you are aware, 38 USC 1517 outlines the employment assistance that may be rendered to a veteran with a service-connected disability who has participated in a Vocational Rehabilitation Program. This assistance may include direct placement, use of Disabled Veterans' Outreach Program (DVOP) counselors, utilization of job development and placement services, assistance in securing a loan for self-employment in a small business, and active promotion and development in the establishment of employment training and other related opportunities. This employment mechanism has yet to be fully developed by the Veterans Administration.

The staff of the Vocational Rehabilitation Department has been shrinking since 1982. With this reduction has come an increased caseload for the Vocational Rehabilitation Specialists now averaging approximately 190 cases per specialist. We believe the optimum caseload to be 100 per specialist. Additionally, the waiting period has increased from 77 days to a totally unacceptable 95 days.

As with any large program, there is a problem with training. The Vocational Rehabilitation Specialist at the local level has not received adequate training in the employment arena, nor has he received the appropriate guidance to clarify individual eligibility.

Title 38 USC 2003(A) allows for three-fourths of the Disabled Veterans' Outreach Programs Specialists in each state to be outstationed at Local Employment Service Offices. DVOPs who are not stationed at the Employment

Service are to be stationed at centers established by the Veterans Administration to provide a program of readjustment counseling. To our knowledge, no DVOPs are presently being used in the vocational rehabilitation arena in accordance with 38 USC 1517. These individuals, with their employment expertise, whose duties and responsibilities are outlined in Section 2003(A) of Title 38, could significantly improve the employment assistance rendered to veterans in the Vocational Rehabilitation Program.

Another problem limiting the effectiveness of the VA's Vocational Rehabilitation Program is the fact that many disabled veterans are not aware of their eligibility under Chapter 31. Apparently members of the armed forces who are placed on the temporary disability retired list are not notified of their eligibility for vocational rehabilitation unless they file for VA benefits. It is our view that these individuals should be informed about their eligibility and that this could be best accomplished by the Physical Examination Board Liaison Officer (PEBLO). This is, in our view, an important aspect of the armed forces' Transition Management Program, which is now under development.

Transition management is going to be increasingly important in the upcoming years. Statistical data project large increases in the number of disability discharges. It has been estimated that disability discharges would be in the range of 22,000 per year throughtout the armed forces over the next five years. At this time, the VA is receiving approximately 4,000 compensation claims per month and this number is expected to increase. DOD estimates that it is presently processing 114,000 discharges per year. Thus, it is evident to us that efficient and effective transition management--the unified effort between reenlistment, in-service recruiter, separation, veterans' affairs, retirement services and educational programs--must guide disabled veterans into the VA's Vocational Rehabilitation Program. We are shocked that necessary information about VA's Vocational Rehabilitation Program is not being provided to disabled veterans discharged from military hospitals or administrative holding companies. Obviously, the goal of transition management should be to assist veterans and disabled veterans effect a satisfactory transition into civilian life. To do the job it must provide these individuals with information about their eligibility for vocational rehabilitation and education. It is also obvious, to us, that the already understaffed VA Vocational Rehabilitation Program will be absolutely crippled unless additional staffing is provided as the demands on the program grow.

Another shortcoming, a veteran in the Vocational Rehabilitation Program cannot be adequately tracked through existing system. The program is relying on 1958 "key punch" technology. This is not sufficient to adequately address the complex and fast changing modern employment market. There is a real need for this program to update its technology.

In summary, Mr. Chairman, with the enactment of Public Law 96-466 and the consequent revision and revitalization of the VA Vocational Rehabilitation Program, much has been accomplished toward affording service-connected disabled veterans the opportunity to find and retain meaningful employment. Still, much remains to be accomplished, and we strongly believe that staffing reductions are adversely impacting the program. You may rest assured that the VFW will continue to work toward the furtherance of this highly valuable veterans' program.

Mr. Chairman and members of the Committee, this concludes my statement and I will be happy at this time to answer any questions you may have. Thank you.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

OVERSIGHT OF CHAPTER 31 PROGRAM

OF TRAINING AND REHABILITATION

S.2462, S.2463, S.2207, S.2396, S.2446, S.2293

S.2459, S.2294, S.2394, S.2419

AND S.2464, BILLS RELATING TO VARIOUS

VETERANS ADMINISTRATION PROGRAMS

JUNE 16, 1988

Mr. Chairman and Members of the Committee, it is an honor for me to speak today on behalf of the members of Paralyzed Veterans of America (PVA). It is with pleasure that PVA presents its views concerning the various Veterans Administration's program issues on the agenda.

I would like to first address the issue concerning oversight of training and rehabilitation for veterans with service-connected disabilities under Chapter 31 of title 38, United States Code.

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The Administration of Chapter 31. Title 38

Mr. Chairman, Paralyzed Veterans of America wishes to extend our sincere appreciation for the inclusion of Chapter 31 oversight among the extensive list of legislative proposals before us today. The successful vocational rehabilitation of our nation's disabled veterans constitutes one of the most productive and potentially cost-efficient programs within the mission of the Department of Veterans Benefits. We compliment you for your continued concern regarding the well-being of this vital program. Today, we specifically compliment you for your efforts to examine and evaluate the manner in which Chapter 31 benefits are administered.

PVA wishes to make several comments regarding the Office of the Inspector General's audit of the VA Vocational Rehabilitation Program. Specifically, the audit addressed three areas:

- ° eligibility criteria and employment services
- ° reported numbers of rehabilitated veterans
- ° employment adjustment allowances

As a result of the investigation, the I.G. has made 12 recommendations they believe would result in reduced program costs, increased program success rates, and more effective use of the $125 million allocated annually for rehabilitating veterans.

PVA notes that the Chief Benefits Director (CBD) was able to concur in 11 out of 12 of the recommendations. We have reviewed the CBD's response to the draft report and concluded that, although the final I.G. report portrays a grim analyses of the Chapter 31 program, the CBD has taken appropriate steps to improve and correct many aspects of the program. We agree with the CBD that the issues under consideration in the audit are often far more complex than the study would indicate.

If the audit's results accurately reflect the degree to which the program suffers, the CBD should implement the I.G.'s recommendations as soon as possible. Although the CBD does not believe that the nature and degree of concerns exist at a level indicated by the audit staff, PVA believes that, ultimately, the disabled service-connected veteran in need of rehabilitation will benefit from the implementation of the recommendations.

I wish to take this opportunity to briefly state PVA's position regarding Chapter 31 eligibility for veterans rated 10 percent and 20 percent service-connected. As stated in Department of Benefits Circular 28-80-3, "the decision as to the veteran's need for vocational rehabilitation is the single most important decision made by counseling psychologists. An incorrect decision might deprive a veteran of services that could improve his or her life or commit the Government to providing costly assistance to persons who do not require such help." When an individual with a 10 percent or 20 percent rating is found in need of rehabilitation, the chances of a training program with cost-efficient, successful results are very good. PVA is supportive of vocational rehabilitation for these individuals who are found to be in need of rehabilitation because of an employment handicap. Our primary concern, however, is that these "easier", cost-efficient training programs, must never come at the expense of the more cost-intensive training programs needed by severely disabled veterans.

The Veterans Rehabilitation and Education Amendments of 1980 (Public Law-96-466) provided a wealth of services and assistance necessary to enable eligible veterans with service-connected disabilities to become employable, to obtain and maintain suitable employment, and to achieve maximum independence in daily living.

Since the enactment of Public Law 96-466, the Vocational Rehabilitation and Education Service (VR&E) has worked to fulfill the mission presented to them by the 96th Congress.

Mr. Chairman, there are several major factors affecting the ultimate ability of the Vocational Rehabilitation staff to fulfill its mission of delivering Chapter 31 benefits in an efficient and timely manner. The most significant of these factors are 1) proposed staffing reductions, 2) employee training programs, 3) the interaction between the Department of Veterans benefits and the Department of Medicine and Surgery, and 4) the Vocational Rehabilitation Program for nonservice-connected pensioners. These four principal components, and management's ability to adequately control and influence the course of each, will determine the degree to which the mission of the Vocational Rehabilitation and Education Service (VR&E) succeeds.

Vocational rehabilitation specialists and counseling psychologists represent the front line of the benefit delivery system within this important program. They must provide benefits in a timely manner and a manner that meets basic quality-of-service standards. They must be both accurate and compassionate in their determinations. Today their mission has been seriously threatened.

Since the enactment of Public Law 96-466 in 1980, the Department of Veterans Benefits has suffered staffing reductions amounting to 4469 staff years. The Vocational Rehabilitation and Education Service reflects this unfortunate decline. Even a cursory review of the statistics illustrates the unmanageable situation VR&E finds itself in today. Full time field staff have been reduced from 598 employees in 1984 to 563 in 1987. VR&E's workload has increased due to independent living programs, vocational training for pensioners, and other employment programs. The average caseload for a VA counselor is now 200 cases compared to 15 to 20 in the private sector.[1] As a result, a disabled veteran must wait three months from the time he fills out the initial application until he has the initial interview with a counselor. Additional unacceptable delays occur during each subsequent phase of the rehabilitation process.

In addition to providing services to enable service-connected veterans to become employable, VR&E has been charged with the responsibility of providing vocational training for nonservice-connected pension recipients. PVA feels the NSC Vocational Rehabilitation Program is one of the most innovative and potentially productive programs to be implemented by DVB in recent years.

Now, at a time when this valuable program is gathering speed, the Administration has proposed yet another staffing reduction for FY 1989 by eliminating 11 more desperately needed personnel in the VR&E staff. PVA thanks this Committee for its efforts to restore funds to the Chapter 31 program. We strongly endorse any effort which would result in the restoration of these vital employees. Additional staffing reductions will only continue to erode the ability of the Vocational Rehabilitation and

Education Service staff to fulfill the mission intended by Congress when PL 96-466 was enacted eight years ago.

Budget constraints have eroded another important aspect of the VR&E program. The service's ability to properly train their personnel has deteriorated significantly in recent years. Inadequate staffing, when coupled with inadequate or nonexistent training, has resulted in a totally unacceptable rate of incorrect decisions and determinations. We are encouraged by the Regional Training Seminars that have been conducted to improve the quality of services provided. We are hopeful that this vital effort is supported by an appropriate number of staff; otherwise, the progress to date will be seriously undermined.

In addition to the ripple effect that staffing reductions have had on DVB and VR&E, the present Target System VR&E must use is inadequate to accomplish the needs of a sophisticated rehabilitation program in the 1980's and 1990's. DVB's need to modernize in order to improve services to veterans while reducing costs is unparalleled in recent history. PVA urges that the modernization effort in DVB information systems be given the very highest priority.

As a member of the Administrator's Advisory Committee on Vocational Rehabilitation, PVA is encouraged by the Administrator's efforts to scrutinize the inner mechanisms of the Vocational Rehabilitation program and propose solutions to existing problems. In our attempt to assess VR&E's ability to interact with VA Medical Centers, however, what we see today is not what the 96th Congress envisioned when Public Law 96-466 was passed in 1980.

Many veterans applying for vocational rehabilitation are able to complete the program by following a prescribed course of education or training followed by employment placement service. Many others, however, are in need of more comprehensive services including extended evaluation and periodic assessments by both VR&E and DM&S personnel. These two departments must efficiently work together as a team in order to reach the ultimate goal of rehabilitating a disabled veteran. We have found that severe problems exist which significantly lessen the probability that such a goal will be achieved.

The following comments are based on PVA's observations and analysis of the working relationship between VR&E and DM&S personnel regarding their attempt to provide adequate vocational rehabilitation service to our Nation's veterans. Our deep concern comes as the result of many interviews with veteran participants, employees of the program, and our own service representatives who have, for years, observed first hand, this combined effort. Without question, the Chapter 31 program and the vocational rehabilitation for pensioners program are getting very little emphasis by the medical centers. The evaluations and rehabilitation efforts required by the program are simply not a high priority with VA Hospital Directors who are more concerned with Diagnotic Related Group's (DRG's) and acute care. The imposition of DRG's has, in our view, fostered an "acute care syndrome" which is detrimental to the goals and objectives of vocational rehabilitation programs. We are concerned that social workers are used primarily to remove impediments to patient discharges and that the current in-house medical system only serves as a conduit to outside services; i.e., accomplish the basics and refer the veteran out of the system.

There is significant lack of uniformity in the methods by which various hospitals approach both Chapter 31 cases and vocational rehabilitation for pensioners. Funding is the bottom line and in most cases it is inadequate to fully implement the required services. Directors must choose between an acute care ward that is short of nurses and a potentially long range evaluation/rehabilitation program for a disabled veteran who is trying desperately to become employable.

There is very little formal training or guidance provided the vocational rehabilitation staff in the medical centers. These are the individuals who are responsible for sending a patient's test scores, behavioral observations, and recommendations to DVB for consideration concerning "feasibility for training" determinations.

Once under DVB jurisdiction, there is very little evidence that DVB and DM&S employ a team concept approach to address and establish mutual goals, conduct follow-ups, make job site visits, or track referrals for those individuals who need extended rehabilitation.

We are also concerned that the low priority given Chapter 31 cases by VA Medical Centers will result in an ever-increasing number of seriously disabled veterans who will be found to be "infeasible for training." In terms of time and resources, it is significantly easier to fully rehabilitate an individual who is rated 20 percent or 30 percent than one who is rated 100 percent disabled.

When budgets are low, this is a tempting way to go. Rehabilitation services to the seriously disabled individual can be cost and time intensive. The actual services provided, therefore, may be influenced by cost factors, particularly, when weighed against the requirements of resources and time needed to successfully rehabilitate a catastrophically disabled veteran.

Finally, parochialism existing in VR&E and DM&S precludes the development of a good united program. The existing managerial and philosophical differences between the two groups assure continued problems in this aspect of the Chapter 31 programs.

Each Regional Office/VAMC rehabilitation program must have a leader, such as a VR&E Counseling Psychologist, with the authority to prioritize the efforts of his vocational rehabilitation team consisting of personnel from both departments. There must be early, united involvement in the motivation, vocational assessment and psychological adjustment of a client. Cooperation, similar philosophies, and, most of all, leadership and direction must be employed by both DVB and DM&S.

In summary, the Vocational Rehabilitation and Education Service desperately needs this Committee and the Congress to restore vital personnel lost to Administration budget cuts. They desperately need a modern ADP system and proper training programs. And finally, the Administrator must take action to enable this benefit program to be delivered by a cohesive and united team, one with identical objectives, and one that can prioritize vocational rehabilitation within the spectrum of all benefit programs and medical activities. Only then does the VA Vocational Rehabilitation Program stand a chance of achieving the standards envisioned by the Congress in 1980.

S. 2462

PVA is pleased to support S. 2462, "Veterans Administration Health-Care Personnel and Programs Act of 1988," introduced by Chairman Cranston. PVA has previously stated our support for extension of readjustment counseling eligibility to include veterans of World War II and the Korean conflict and after May 7, 1975, the end of the Vietnam era. First, as currently constituted, readjustment counseling usually provided in community-based Vet Centers is a proven effective and cost-efficient method of addressing the mental health needs of veterans who are experiencing difficulties with the transition back into civilian life.

The VA's own analysis of the Vet Center Program has found that the storefront setting is a very éffective means of outreach and direct service to the veteran population. PVA has felt for a longtime that, without significant, additional cost, the mission of these Centers could be broadened and, where feasible, help meet the growing needs of other categories of deserving veterans.

Section 3 of S. 2462 would authorize $500,000 to be used by the Administrator for making grants to the Veterans Memorial Medical Center (VMMC) in the Philippines to replace and upgrade equipment and in rehabilitating the physical plant and authorize contracts for certain care and treatment of U.S. veterans in the Philippines. PVA is supportive of this provision as it is important to the maintenance of health care to eligible veterans in the Phillipines. However, we must be assured by the VA that the authorization for minor construction of the VMMC will not take place in front of other, higher priority projects here in the United States, as there are many VAMC's which are in need of upgrades.

PVA supports Section 4 of S. 2462 which will facilitate employment of title 5 health-care personnel who were appointed and successfully participated in a Veterans Administration affiliated clinical education program. We believe this provision is important to the over-all enhancement of VA recruitment initiatives, and we are happy to also see the support of the VA itself on this initiative through the introduction of S. 2394, a similar measure, also on today's hearing agenda.

For the purpose of enhancing VA retention mechanisms, PVA is also pleased to support Section 5 of this bill to decrease the time allowed for the Office of Personnel Management to approve or disapprove VA proposals for special rate authorization for title 5 individuals employed at VA health-care facilities.

PVA supports Section 6, regarding disciplinary actions and grievances, pertaining to title 38 employees as we believe this provision will establish consistency in employer-employee relations throughout the VA regardless of title 5 or title 38 designation.

PVA supports Section 7 of S. 2462 which will expand the authorization of the Administrator to enter into sharing agreements for the purpose of sharing scarce medical resources at all VA health-care facilities at rates that provide appropriate flexibility to the heads of those facilities. To date, VA sharing agreements have proven to be a cost-effective method of scarce resource allocation. Flexibility in rate allows for greater application and use of such agreements in areas where geo-economic discrepancies exist. However, PVA must reiterate the strong need for the VA to maintain close oversight, monitoring and quality control mechanisms.

PVA applauds the efforts of the Chairman in reauthorizing Subchapter II of Chapter 82 entitled "Assistance to Public and Nonprofit Institution of Higher Learning, Hospitals and Health Manpower Institutions" to establish cooperative arrangements with universities, colleges, junior colleges, community colleges and schools of allied health professions. PVA believes that enactment of this provision will be very beneficial in improving the serious nursing and allied health professional shortage currently being experienced by the VA. Especially when coupled with Section 4 of this same bill which will facilitate the process by which some of these new graduates may obtain VA employment, PVA believes this provision will go far towards easing a perplexing health-care crisis in the VA.

Also with respect to VA recruitment and retention efforts, PVA is pleased to support Section 9 which authorizes pilot programs of pay and personnel management practices. We note that this provision had been previously introduced as an amendment to S. 9 during the last Session of Congress, and we are hopeful that this important provision will be successfully enacted this Session. PVA, in previous testimony before this Committee, emphasized the need for a variety of both short and long term solutions to address the shortage of health care professionals in the VA. We commend you, Mr. Chairman and Senator Murkowski, for providing the foresight and leadership to steer the Committee towards that end. This Committee has responded to this crisis with a multitude of creative and, quite frankly, admirable legislative solutions. It is evident to PVA that your commitment is so strong that you won't quit until this serious threat to the quality of VA health care delivery is overcome. The Members of the Committee and your staff deserve a great deal of recognition for your steadfast efforts.

Bonus pay, Saturday premium pay and certain other provisions, enacted as Public Law 100-322, are all quick-fix solutions, and they will certainly go far towards helping to ease the shortage of VA health care professionals. The pilot program authorized in Section 9, however, is a long-term solution with a critical eye towards the future of VA health care delivery. The need for these provisions are based on recommendations of a study by the American Academy of Nursing which was done between 1980-1983 in response to the severe shortage of RN's in the late 1970's. The private sector began almost instantly to implement the recommendations of this study and two others. The VA, however, has been struggling to introduce innovative management practices and has a long way to go to become competitive in hiring and retaining staff. This provision is necessary in order for the VA to keep pace with, or even surpass, the progression of recruitment and retention practices outside the VA. PVA is fully supportive of Section 9, and we are optimistic that the reports of the CMD on the pilot program will identify potential areas of positive progression for the nursing profession now and in the future.

In addition however, to increasing the scope of responsibility for nursing administrators to include services other than nursing, PVA believes that the Chief Nurse position must also be elevated in the management structure. PVA believes that little impact will be realized unless the management structure is reordered so that the nursing leadership position is elevated from Chief to Associate Director status, with the individual reporting directly to the facility director rather than to the Chief of Staff. With the nurse leader at that level, the facility director, in essence, is "sending a message" to other senior administrative staff that nursing is an autonomous service, accountable for all areas of clinical nursing practice.

PVA supports Section 10 of S. 2462 which will provide for further research and information relating to Post-Traumatic Stress Disorder (PTSD). PVA strongly agrees with Chairman Cranston that the VA must assume a visible and significant leadership role in the diagnosis, treatment and care of veterans who manifest this disorder.

S. 2463

PVA is supportive of S. 2463, a bill to establish up to five Mental Illness Research, Education and Clinical Centers (MIRECC) at designated VA Medical Centers. PVA believes that the VA must take an active and significant role in the quest for research and education with regard to mental illness. The finding in the Kety Committee Report in 1985 revealed that less than 10 percent of VA research resources are designated to mental illness, while at the same time the VA is providing 40 percent of all bed-days to treatment of mental illness. This is very disturbing. Perhaps even more disturbing is the fact that the VA has repeatedly ignored specific report language from

Congress to elevate the priority of research relating to mental illness. PVA, therefore, is supportive of S. 2463 which mandates the establishment of research centers dedicated towards pursuit of new knowledge and data collection in this critical area.

S. 2207

PVA is particularly pleased to address S. 2207, introduced by Senator Murkowski. This bill will amend title 38, United States Code, to specifically authorize the Administrator to provide assistive animals to certain quadriplegic veterans. Specially trained assistive animals (specifically, Canines and Simians) are a proven means of helping disabled individuals pursue greater independence, rehabilitation, recreation and social interaction.

One program, Canine Companions for Independence (CCI) pioneered the concept of training dogs to help people with disabilities other than blindness. CCI was founded by Bonita M. Bergin in 1975. Now, 13 years later CCI has placed hundreds of Canine Companions with disabled individuals. From retrieving objects and turning on and off a light switch for someone using a wheelchair, to alerting a deaf person to the sounds of a child crying or the phone ringing, these dogs are providing an essential link towards greater independence. To date, CCI has placed over 300 dogs, the total cost to the disabled individuals is $125.00.

The VA has funded extensive research on the training of Simians to function in an assistive capacity to severely disabled individuals in the home setting. The research, which PVA has also funded, has resulted in the development of a comprehensive program founded and directed by Dr. Mary Jane Willard of Boston University whose goal is the routine placement of specially trained monkeys with quadriplegic individuals - much like guide dogs are now provided to blinded veterans.

These monkeys perform for the quadriplegic individual a multitude of tasks which, because of the level of spinal cord injury, the person is unable to perform himself. It is estimated that in order to live outside the institutional setting, a high level quadriplegic typically requires a minimum of four to six hours per day of human assistance. Usually, the individual receives this help from a family member or personal care attendant (PCA).

The relative or PCA assists with tasks such as dressing, bathing, medical treatments, etc. In addition to these tasks, the individual may also require help to perform countless small tasks throughout the day such as putting a book on a reading stand, getting a drink or eating a meal, turning on a light, retrieving a fallen object, or opening a door.

PVA, as an advocate for greater independence for our catastrophically disabled members recognizes the importance of continual improvement in the quality of life of these individuals through the use of assistive animals who can, when successfully trained, decrease the level of dependence on human assistance. Much in the same way that guide dogs have resulted in greater independence for the blind, specially trained monkeys and canines can open up avenues to independence for the catastrophically disabled veteran, providing for enhanced, social interaction, educational and employment opportunities.

Specific statutory authority, however, to provide this necessary service is not included in title 38. PVA requests the assistance of the Veterans' Affairs Committees to amend Chapter 17 of title 38 to include the provision of assistive animals to eligible veterans. All the successful research efforts and expended resources will prove fruitless if necessary authorizing legislation is not promptly enacted.

We want to state our appreciation to you, Senator Murkowski, for the introduction of S. 2207 and to you, Chairman Cranston, for your recognition of the merits of this legislation and for the expeditious manner by which you have scheduled this hearing. We also want to thank Dr. M.J. Willard for her successful research efforts and for her enthusiasm and determination in guiding her ideas into the reality of a comprehensive program which will provide for maximal improvements in the quality of life for many catastrophically disabled veterans.

S. 2396

PVA is opposed to S. 2396, "Definition of Vietnam Era," introduced by Senator Mitchell, to amend Title 38, U.S.C., to expand the period considered as the Vietnam era in the case of veterans who served in the Republic of Vietnam.

PVA does not object to extending, or the effort to change, the beginning period of the Vietnam era from August 5, 1964 to February 28, 1961. Specifically, what we are opposed to is that the bill is limited in only recognizing veterans who served in the Republic of Vietnam.

PVA views the Vietnam era as being a period of such a magnitude of involvement that recognition for the service of all veterans who served during this period must be included, whether they served in the Republic of Vietnam or not. We respect and appreciate Senator's Mitchell's efforts to change the date, however, we could support the bill if it were further amended and inclusive of our stated concerns. To PVA any effort to exclude by not recognizing the faithful service and logistical military support of United States troops who served during this period outside of the borders of Vietnam is unthinkable.

S. 2446

PVA supports S. 2446, introduced by Senator Rockefeller, to extend for one year the authorization of the VA to furnish respite care and to extend the due date for a report on an evaluation of the Respite Care Program.

PVA wholeheartedly supports the concept of Respite Care. Most individuals with chronic conditions can and do live outside the permanent confines of a hospital or nursing home setting. PVA promotes the concept of its members obtaining and maintaining optimum levels of independence afforded by living in the community. For our members with chronic and catastrophic disabilities, it is often a life of dependence upon one's family or primary caregiver to maintain a life outside of an institutional environment. The simple provision of an opportunity for respite care can often mean the difference of a veteran having to choose between life within an institution or in the community at large.

PVA looks forward to the findings of the VA's evaluation of the Respite Care Program, and we support continuation of this worthwhile program for one year, rather than the two-year authorization requested by the VA in Section 5 of S. 2294.

S. 2293

PVA will address our concerns regarding S. 2293, a bill introduced by Chairman Cranston (by request), to raise the VA's minor construction limitation and to require the Administrator to consider VA-DOD sharing agreements when projects cost over $2 million.

Minor construction projects are used by VAMC's to accomplish many facility construction projects that, although not relatively costly, are critically needed. Increasing the threshold to $3 million will undoubtedly increase the opportunity for each VAMC to satisfy those needs without having to request a major construction project. It may, however, exacerbate an existing problem. The 1985 Booz, Allen and Hamilton/RTKL Study identified a problem with the minor construction project process. VAMC's will lump several minor projects together to accomplish what otherwise should have been accomplished with a major construction project. This often leads to a poorly planned, disjointed development of a medical facility. The project becomes "dollar driven" vs. "needs driven." The Facility Development Planning (FDP) Program will minimize this problem, if minor projects are required to be reviewed in the context of the FDP. Otherwise, PVA has no difficulty in supporting the increased threshold.

The amendment of Section 5002(d) to include the consideration of sharing with DOD is a little more complex. On the surface, there is merit in recognizing common medical facility needs with DOD. But therein lies the problem. We have testified on numerous occasions that the VA does not have a mechanism for determining medical facility needs as a basis for resource allocations. The proposed amendment language presumes that the VA can quantify and qualify their own needs, and somehow factor in the needs of DOD.

Secondly, it requires the Administrator to consider, for sharing with DOD, all construction projects costing over $2 million dollars. PVA believes this represents a dangerous and undesirable precedent for merging all VA and DOD health care projects in the future. Therefore, we strongly oppose this provision. While great success has been realized with VA-DOD resource sharing agreements in the past, PVA believes that each agreement should be weighed individually and on its own merits and only if viable options for free-standing VA facilities are unavailable.

S. 2459

Paralyzed Veterans of America wishes to commend Senator John D. Rockefeller for introducing S. 2459, "Veterans' Vocational Training Continuation Act of 1988." This bill would extend the pilot program of vocational training for veterans awarded nonservice-connected pension benefits.

Mr. Chairman, I extend PVA's appreciation, once again, for this Committee's efforts in the 98th Congress which resulted in the passage of PL 98-543.

This four year program, which is presently due to expire on January 31, 1989, represents, in our view, one of the most innovative and potentially productive programs to be implemented by the Department of Veterans' Benefits in recent years. Senator Rockefeller's effort to extend this program to January 31, 1990, underscores the original intent of the legislation which was to (1) provide a cost-effective method by which pension rolls and expenditures could be reduced; (2) alleviate the ever-increasing demands placed on the VA's health care system by returning individuals back into the private sector through utilization of employee provided health benefits, and (3) restore new hope to an individual to achieve a productive and meaningful life.

S. 2459 would also continue to protect health care eligibility for three years for those individuals whose pension has been terminated due to the successful completion of the vocational rehabilitation program and subsequent employment.

Senator Rockefeller has stated that, by all indications, this temporary program is accomplishing what the Congress had intended it to accomplish. PVA appreciates that the proposed one year extension will afford the Congress further opportunity to access the advisability of making the program permanent and of possibly expanding it to make previous recipients of pension awards eligible.

Although we are most grateful for the introduction of S. 2459 and certainly endorse the intent of such legislation, PVA would encourage this Committee to consider (1) extending the pilot program until January 31, 1992, (2) eliminating the present 3,500 case limitation, (3) opening the program to recipients under age 50 who were awarded pension before the original pilot program, February 1, 1985, and (4) extending the health care eligibility to a five year period.

It is our belief that the sooner an individual is exposed to a viable alternative to permanent unemployability, the more likely it is that he will find success in vocational rehabilitation. We continue to maintain that the nonservice-connected pension program contains built in work disincentives which, over the years, have led to unnecessary dependency on government expenditures. By expanding the vocational rehabilitation program and offering this valuable service to all "under 50" pension recipients, we could greatly improve the probability that this program will succeed.In this regard, our concern is with the present 3,500 case limitation on the program. As an increasing number of eligible veterans take advantage of this worthwhile service, a limitation on the number of applicants will prohibit the VA from realizing the maximum return potentially available if the program is fully implemented. This limitation may not be an immediate concern, but we urge this Committee to obtain meaningful statistics from the VA in order to determine if there are veterans who would be "feasible for training," yet are unable to participate because of a limit on the number of pensioners that can be evaluated. PVA understands that DVB staffing reductions have made it difficult to adequately implement and monitor this program and its many contributions. We are hopeful, however, that the Congress will be successful in reversing this trend in order that the VA can rightfully fulfill its mission of providing timely and effective services. We applaud your efforts to restore these desperately needed personnel to DVB.

Finally, Section 525, Title 38 U.S.C., presently provides health care eligibility for three years to those individuals whose pension has been terminated due to the successful completion of the vocational rehabilitation program and subsequent employment. PVA is concerned that this provision may likely deter a potential applicant who otherwise can rely on Category A medical care for the rest of his life. We feel that since this individual would be eligible for priority health care anyway, it would be beneficial to the long term success of the program to extend this temporary health care coverage to provide Category A medical services for a five year period. After this temporary period, the veteran would be subject to the existing means test to determine the appropriate category of eligibility. It is very likely that such an individual will utilize employer provided health benefits and will therefore not be a burden on the VA health care system.

S. 2294

PVA is pleased to respond to certain provisions contained in S. 2294, "Veterans Administration Health Care Amendments," introduced by Senator Cranston by request of the VA.

Section 2

PVA supports Section 2 of S. 2294 which provides ongoing authority for the VA to contract for alcohol and drug abuse treatment services. The recent report issued by the VA was favorable. Based on this report, PVA believes that the Alcohol and Drug Abuse Treatment Program should be established as permanent.

Section 3

Section 3 extends for two years the VA's authority to provide Respite Care Services. As stated previously in this testimony, PVA supports a one year extension of this worthwhile and cost-effective program.

Section 4

PVA supports Section 4 which clarifies the authority of the VA to pay for emergency medical services for veterans participating in a vocational rehabilitation program under Chapter 31 of title 38, United States Code.

PVA believes this provision is necessary to clarify and broaden the VA's authority and ensure that veterans participating in VA vocational rehabilitation programs are able to obtain emergency medical care when a VA or other Federal facility is unavailable.

Section 5

Section 5 pertains to authorization for medical care in the Philippines. PVA supports this section as previously stated with regard to Section 5(b)(1) of S. 2294, as introduced by Senator Cranston.

Sections 6, 7 and 8

Sections 6, 7 and 8 pertain to matters already enacted this year as Public Law 100-322.

S. 2394

PVA supports S. 2394, a bill introduced by request, by Chairman Cranston, with regard to Civil Service hiring practices as we stated previously today in our support of Section 4 of S. 2462.

S. 2419

PVA is opposed to amend Sec. 2 of S. 2419, "Veteran's Housing Amendments Act," introduced by Chairman Cranston (by request). Our first area of concern involves the Administration's proposal, once again, to repeal the VA's current authority to set the maximum interest rates at which lenders can make guaranteed loans. This legislation would allow that loans guaranteed or insured under Chapter 37 of Title 38 be payable on such terms and conditions as may be agreed upon the veterans and the lender. These negotiated interest rates would bear such interest for the lifetime of the loan. As the House Committee on Veterans' Affairs report to the House Committee on the Budget, March 10, 1988, so clearly points out, such loans would have several adverse effects on the VA Loan Program and the veterans utilizing it. We agree that veterans would end up paying higher interest rates which would result in the erosion of their purchasing power. These rates would translate into higher mortgage payments and would ultimately have an adverse effect on the Loan Guaranty Revolving Fund.

In addition to the points expressed in the March 10 report, we are concerned that if the Administration's proposal of negotiated interest rates were implemented, the "no down payment' feature of the VA Home Loan Guaranty Program would be jeopardized. Since the inception of the Home Loan program over forty years ago, the dream of home ownership has been made possible, primarily, because veterans and military service personnel were not forced to liquidate their life savings in order to make the down payment on a home.

PVA believes that in order for a veteran to negotiate and secure a favorable interest rate, it quite possible would be necessary for the veteran to make a sizable down payment, thereby removing one of the most advantageous features of the program. Such a proposal would remove the incentive for veterans to participate in the program. It would also place the veteran borrower in a situation where he would have to seek out favorable terms and be forced by lenders to accept above market rates.

Section 3

PVA offers several recommendations in regard to improvements and innovations in the VA Home Loan Guaranty Program. First, as we have stated in the previously submitted Independent Budget, an accurate estimate of the needs for the VA's Loan Guaranty Revolving Fund is difficult to ascertain. A significant part of the problem is due to economic and market conditions that are extremely adverse in certain areas of the country. We urge the Congress to fully address the programmatic and financial problems of the fund.

Regarding the sale of such loans without recourse will result in reduced sale prices paid to the government. The government's return will be maximized however, if vendee loans are sold with recourse. In any event, the Administrator must ensure that proceeds to the Loan Guaranty Revolving Fund are maximized.

In conclusion, although long range solvency is a priority, PVA stresses the fact that VA guaranteed home loans are, in fact, benefits for veterans. The intent of Chapter 37, Title 38, is to provide a certain degree of protection for the veteran home buyer and to enable the veteran to purchase a home with a degree of financial advantage. In our effort to provide long term solvency, we must not trade off veterans' benefits in favor of provisions that would benefit the mortgage company or lender.

Section 4

PVA is agreeable of this amendment to repeal certain manufactured home loan requirements. We are supportive as long as the intent to ensure that home construction safety and quality standards are maintained. It is important to ensure that the veteran and the VA are protected against shoddy construction.

Section 5

PVA favorably supports the amendments to repeal of the requirement for a statement of local officials regarding the feasibility of public or community water and sewerage systems as a condition to the VA guaranty of loans for the purchase of newly constructed homes.

Section 6

PVA opposes this amendment to permit VA to collect all debts arising out of the housing loan program by offsetting the debtor's Federal Tax Refund.

PVA does not object to the collections of legitimate debts, however, we have serious concerns regarding the Administration's efforts to utilize tax refunds to offset home loan indebtness. This committee should be cautioned not to endorse any provision which would impose financial hardship where it obviously already exists. PVA is generally not in favor of such an offset.

Section 7

PVA is not objectionable to this amendment to impose a time limit of 180 days after receiving notice of a housing loan debt for a veteran to request that VA waive that debt.

S. 2464

PVA favorably supports S. 2464, "Veterans Administration Insurance Amendments of 1988," introduced by Senator Alan Cranston (by request). We believe that by increasing the discount rates this will serve to benefit the veteran and/or his beneficiaries. It will further serve as an incentive for veterans to make lump sum annual or semi-annual payments which would further reduce the administrative burden and consequently result in a cost-savings to the VA. Thank you, this concludes our statement.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

June 22, 1988

The Honorable Alan Cranston, Chairman
Senate Committee on Veterans' Affairs
SR-414 Russell Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

PVA is pleased to support S. 2511, a bill to establish a pilot program for providing assistive monkeys to certain veterans. Although PVA cannot determine any compelling reason not to support permanent authorization of this important service, we yield to the expertise of the Committee, under your leadership, in making such determination.

PVA appreciates the opportunity to express our concerns regarding specific aspects of the pilot program which we respectfully call to your attention.

S. 2511, as introduced, requires a complex and lengthy report and evaluation at the termination of the three-year authorization. We believe that this requirement implies that there has not been sufficient testing and that the research, to date, has been inconclusive. This certainly is not so and, in fact, Dr. Peg Giannini indicated at the Committee hearing that it was fairly certain that an 18-month comprehensive final evaluation of the Helping Hands Program would begin in the very near future.

PVA is concerned that the results of this evaluation, coupled with the results of the comprehensive evaluation, mandated in S. 2511 might yield somewhat redundant findings.

Secondly, with respect to the final evaluation, PVA believes that enough research and data has been compiled and that some of the more specific programmatic concerns (i.e. what happens to the monkey when the veteran is hospitalized) will be conceivably answered in the early stages of the pilot program. We suggest that either the reporting requirements be waived, if the results of the 18-month VA evaluation are positive and conclusive, or that the VA be required to conduct an on-going evaluation of the pilot program with the report due before the end of the three-year authorization. PVA believes that either approach will avoid unnecessary, and often lengthy, delays in the provision of this important service during the evaluation phase.

PVA believes that S. 2511 should also address the question of disposition of the 20 monkeys already placed with veterans, should the program not be reauthorized, nor made permanent. We would strongly suggest that the monkeys become the property of the veteran, since it would be unfair to establish a reliance on these assistive animals only to sever this reliance abruptly. We believe further clarification on this point is warranted.

PVA has serious concerns regarding Section 1, 2(B) of S. 2511, which requires the Administrator's views on the relationship between the provision of a monkey and the payment of aid and attendance to the veteran. PVA believes this provision needs clarification.

Assistive animals are a proven and effective supplement to, not substitute for, aid and attendance to quadriplegic veterans. The provision of this service has never intended to replace or compete with the absolute necessity of human intervention. The presence of a specially trained monkey in the veterans' household can, however, have a very positive effect on the ability of the veteran to recruit and retain attendant caregivers, by helping to increase the functional independence of the quadriplegic individual. PVA respectfully requests that Section 1, 2(B) of S. 2511 be revised to require the Administrator to study the effects which the placement of a monkey in a household has on the quality of life of the primary caregiver and if, in fact, recruitment and retention of qualified aid and attendance caregivers is enhanced.

PVA has been concerned about the inadequacies of the VA's aid and attendance provision for quite some time, and we believe this issue warrants Congressional attention in the near future. We do not believe however, that analysis of the VA's provision of aid and attendance is appropriate as part of the evaluation of a pilot program providing assistive animals. PVA would be happy to work with the Committee, in a future forum, with the purpose of oversight of VA aid and attendance.

Finally, PVA is supportive of Section 2 of S. 2511, which would authorize the signal dogs pilot program. We believe, however, that the language should be expanded to include the use of service dogs which have also proven to be an effective and worthwhile supplement to increasing the functional independence of the veteran. We believe, too, that there may be veterans whose needs are better suited to an assistive canine rather than an assistive monkey. We respectfully suggest that Section 2 be revised to allow for up to 10 service dogs and up to 10 signal dogs with 20 dogs placed over all, depending on the proportion of veterans requesting such assistance and the nature of their particular disability. At the very least, PVA believes that the VA should obtain and compile the number of veterans who request the use of service canines with the subsequent authorization of service canines should an analysis of the demand prove significant.

The Honorable Alan Cranston
June 22, 1988
Page Three

PVA is very appreciative to you, Mr. Chairman, for your commitment to this issue and for your commitment to review and propose revision of Chapter 17, title 38, U.S. Code. We are hopeful that this review will result in a revision to preclude the need for congressional authorization of pilot programs in the future with regard to new technologies and programs, particularly those which are funded and researched by the VA itself. PVA believes that the VA should have some mechanism to internally institute such programs without the continual need to seek legislative authority.

PVA supports section 9 of S. 2294, which would extend the authorization of appropriations for the State home construction grants from October 1, 1989, through September 30, 1992.

In addition to authorizing the appropriation of $500,000 for construction and equipment upgrades at the Veterans Memorial Medical Center in Manila, section 5 of S. 2294 would require that $50,000 of such funds be used for the purpose of educating and training health service personnel who are assigned to the VMMC. PVA supports favorable consideration of section 5, S. 2294.

For the record, the above comments are in addition to PVA's statement submitted on June 16, 1988, before the Senate Committee on Veterans' Affairs.

Again, our sincere thanks to you and your staff for your efforts to authorize the provision of assistive animals to quadriplegic veterans.

Sincerely yours,

Frank R DeGeorge

Frank R. DeGeorge
Associate Legislative Director

FRD/df

Veterans
Administration

Office of Inspector General

AUDIT OF VA VOCATIONAL REHABILITATION PROGRAM

REPORT NO: 8R6-B99-045

DATE: MARCH 21, 1988

SUMMARY

The Office of Inspector General made an audit of the VA vocational rehabilitation program to determine whether the program effectively and economically accomplished its intended purpose of rehabilitating veterans. The VA spent about $125 million annually to provide vocational rehabilitation services for about 27,000 veterans.

The vocational rehabilitation program provides all services and assistance necessary to enable veterans who have service-connected disabilities that materially contribute to employment handicaps to become employable and obtain and retain suitable employment. The audit included reviews of eligibility determinations, selections of specific training programs, accuracy of reported program success rate, and the appropriateness of employment adjustment allowance payments.

The audit concluded that the VA vocational rehabilitation program was not sufficiently effective and was not economically accomplishing its intended purpose of rehabilitating veterans. Audit results showed that many program participants did not need the vocational rehabilitation training that they received (page 3). The program's reported success rate was significantly overstated and only about 6 percent of the 27,000 participants were rehabilitated (page 13). The audit also disclosed that payments of employment adjustment allowances were not always appropriate (page 22). Establishment of new policies and internal control procedures would reduce program costs and make more effective use of about $125 million allocated annually for rehabilitating veterans. Nothing came to our attention that would indicate that untested items were not in compliance with applicable laws and regulations.

The Chief Benefits Director concurred with 11 of the 12 recommendations, but took issue with some of the report contents. The Chief Benefits Director also stated that the nature and degree of concerns exist at a level lower than indicated by the audit. Although he disagreed with Recommendation 3, the Chief Benefits Director stated that program staff are examining payment of the employment adjustment allowance and that this examination will likely result in adjustment of policy, and probably, recommendations for legislative or regulatory change in this area. This recommendation will be considered unresolved until the planned examination is completed. All other recommendations are considered resolved based on adequate implementation plans presented by the Chief Benefits Director.

Office of Inspector General
OFFICE OF INSPECTOR GENERAL

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PART I

INTRODUCTION

A. Purpose

The Office of Inspector General made an audit to determine whether the VA vocational rehabilitation program effectively and economically accomplished its intended purpose of rehabilitating veterans. Specifically, the audit was made to:

-- Determine whether veterans enrolled in the program met established eligibility criteria and were provided the services needed to obtain employment consistent with their abilities, aptitudes and interests.

-- Validate the reported number of rehabilitated veterans (those who completed the training program and obtained steady employment in occupations related to their training or comparable occupations.)

-- Determine whether employment adjustment allowance payments were appropriate.

B. Background

The VA vocational rehabilitation program provides all services and assistance necessary to enable eligible veterans to become employable and to obtain and retain suitable employment. To be eligible for participation in this program, veterans must have service-connected disabilities that materially contribute to employment handicaps.

Public Law 96-466, the Veterans Rehabilitation Education Amendments of 1980, substantially revised the program. These amendments emphasize that the goal of the program is to obtain suitable employment for participants. Previously, program success was measured in terms of participants who completed approved training programs. The amendments also require that program resources be focused on veterans who have serious employment handicaps.

The VA reported that about 27,000 veterans participated annually in the vocational rehabilitation program and about 3,400 (12.6 percent) were rehabilitated. Participating veterans received subsistence allowances of about $68 million. The VA also spent about $37 million for veterans' tuition, fees, books and other expenses. The program is administered by program officials in VA Central Office and 57 Regional Offices. The Vocational Rehabilitation and Counseling Service had 567 full-time equivalent employees with a staff cost of about $20 million annually. Total cost of the VA rehabilitation program is about $125 million annually.

C. Scope

We reviewed program results in the vocational rehabilitation program at VA Central Office and reviewed veterans' records maintained at 37 Regional Offices. The Regional Offices included in the audit are listed in Exhibit 2. We reviewed claims folders, vocational rehabilitation folders, counseling folders, Emergency Veterans Job Training Act folders, computer master records (TARGET) and finance records of selected veterans.

Audit work included:

- Review of 130 veterans' records randomly selected via statistical sampling techniques to determine whether veterans enrolled in the program met established eligibility criteria and were placed in training consistent with their abilities, aptitudes and interests.
- Validation of the reported number of rehabilitated veterans. We reviewed records of 72 randomly selected veterans who were reported as rehabilitated.
- Discussions with State vocational rehabilitation officials and Department of Education officials to determine the eligibility criteria and success rates of other rehabilitation programs.
- Contacts with Federal and State vocational rehabilitation officials to determine whether veterans received duplicate benefits from States.
- Review of implementing procedures for payment of employment adjustment allowances.

The audit was made in accordance with generally accepted government auditing standards.

PART II

RESULTS OF AUDIT

A. Findings And Recommendations

1. Program Participants Did Not Always Require Vocational Rehabilitation Training Provided

Finding

Many program participants did not need the vocational rehabilitation training they received. This occurred because counseling psychologists did not clearly establish that veterans had employment handicaps and service-connected disabilities materially contributed to employment handicaps. Further, veterans were placed in training programs that were incompatible with their disabilities or inconsistent with their abilities, aptitudes, or interests. As a result, program funds of about $45 million were spent annually for training that was unneeded or inappropriate.

Recommendation 1

We recommend that the Chief Benefits Director:

a. Require counseling psychologists to comply with existing procedures by contacting current or former employers of veterans with substantive employment histories to determine whether service-connected disabilities were contributing factors to loss or retention of employment.

b. Establish policy requiring that employment services be provided before attempting retraining of veterans whose service-connected disabilities did not prevent them from obtaining or retaining suitable employment.

c. Notify counseling psychologists that more emphasis needs to be placed on documentation of past employment, prior academic work and veterans' abilities, aptitudes and interests when making eligibility determinations and identifying vocational rehabilitation training to be recommended for veterans.

d. Reconfirm established policy that unique factors concerning military retirees must be carefully considered before authorizing entry into vocational rehabilitation training by veterans who retired with 20 or more years of active service.

Discussion

a. Background

Title 38, United States Code, Section 1502 provides that an otherwise eligible veteran is entitled to a rehabilitation program if it is determined by the Administrator that the veteran is in need of rehabilitation training because of an employment handicap. An employment handicap is defined as an impairment of a veteran's ability to prepare for, obtain, or retain employment consistent with the veteran's abilities, aptitudes and interests.

Title 38, Code of Federal Regulations, paragraph 21.51 (h) requires that the determination as to the existence of an employment handicap must be made by a counseling psychologist assigned to the Vocational Rehabilitation and Counseling Division in VA Regional Offices. The policy also provides that an employment handicap does not exist when the veteran's employability is not impaired; the veteran's service-connected disability does not materially contribute to an impairment of employability; or the veteran has overcome the effects of impaired employability through employment in or qualification for employment in an occupation consistent with his or her abilities, aptitudes and interests.

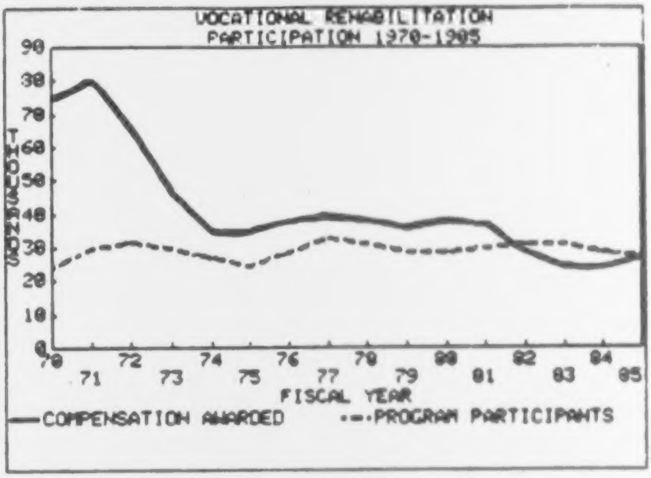
VA policy contained in Department of Veterans Benefits Circular 28-80-3 provides that the decision as to the veteran's need for vocational rehabilitation is the single most important decision made by counseling psychologists. An incorrect decision might deprive a veteran of services that could improve his or her life or commit the Government to providing costly assistance to persons who do not require such help. The policy requires that these decisions be based on facts that are "...clear, specific, and convincing..." When determining the existence of an employment handicap, counseling psychologists are required by Appendix D of the Circular to consider these experiences of the veteran:

- education and training prior to military service;
- military training and assignments; and,
- postmilitary employment, education, and training.

When a record of substantive employment is known, the counseling psychologists are required to contact employers to learn of that experience.

b. **Program Statistics**

There were about 27,000 service-connected veterans receiving rehabilitation training at the time of audit. The number of veterans participating in the vocational rehabilitation program has remained relatively constant over 15 years; however, the number of veterans initially awarded compensation for service-connected disabilities during that same time has decreased significantly. The chart below shows this trend:



Specifically, program statistics for FY 1970 show that service-connected awards (75,000) were more than three times the number of program participants (24,000), while in FY 1985, service-connected awards (26,600) were about equal the number of program participants (27,000). To determine whether program participants met eligibility criteria for entry into the vocational rehabilitation program, we reviewed records of 130 veterans who had been approved for training during the year ended February 1986.

c. **Not All Veterans Needed Rehabilitation Training Provided**

In our opinion, 65 of the 130 veterans (50 percent) should not have been provided with the rehabilitation training they received. In total, 46 veterans did not have employment handicaps or their service-connected disabilities did not materially contribute to impairment of employability and, in 31 instances, the approved training was not consistent with the veterans' abilities, aptitudes and interests. Twelve veterans were included in both categories.

d. Questionable Determinations Of Employment Handicaps

Forty-six veterans did not need rehabilitation training because they had obtained and retained stable employment, or they had histories of substantive employment. These veterans' service-connected disabilities had not prevented them from obtaining or retaining jobs. To illustrate, we found that 19 of the 46 veterans were employed when the VA counselor determined that they needed rehabilitation training. The records for these 19 veterans showed that 18 continued to work while in training. The one veteran quit work to attend school, but dropped out after 3 months because he obtained a job that was unrelated to his training.

Our analysis of the records for these 19 veterans showed that 15 were no longer in training at the time of audit. Four of the 15 veterans had completed their training program, but continued to work at the same job they held before, during and after training. The other 11 veterans dropped out of training, but continued to work at jobs they had obtained without VA assistance. For example, one veteran had been employed as a postal carrier for 4 years when he was approved for rehabilitation training. His rated disability was 10 percent for a knee condition that had not increased in severity since his discharge in 1975. He pursued an associates degree in business administration for 15 months on a part-time basis while he continued to work full-time for the Postal Service. He dropped out because he was working long hours at the Post Office and his work schedule conflicted with his training. None of the training provided for these 15 veterans was used to change vocations. In our opinion, the facts in these cases did not clearly, specifically and convincingly demonstrate that these 19 veterans had employment handicaps.

Twenty-seven veterans did not need rehabilitation training because they were able to obtain employment in the past and the files did not contain evidence that their service-connected disabilities prevented them from obtaining and holding jobs. We concluded that these veterans only needed assistance in finding jobs rather than training and that some veterans were not interested in employment. Twelve of the 27 veterans were still enrolled in their training programs, therefore, we could not evaluate the ultimate impact of their training on future employment. However, records for the other 15 veterans revealed:

- Five veterans completed their training programs, yet the records did not show that they had obtained employment. These veterans were furnished no employment assistance from VA personnel. Based on available records and veterans' actions, we concluded that these veterans were not interested in employment. To illustrate, we identified a 53-year-old veteran who retired in 1981 from the military after 28 years on active duty and had not worked since retirement. He completed a 12-month training program to become a bricklayer. The veteran then informed VA personnel that he was not seeking employment and planned to attend a 12-month course under another VA educational program.

- Six veterans quit training because they found employment on their own. These jobs were unrelated to their training programs. For example, one veteran (10 percent rating for back condition that had not worsened since he left military service in 1974) was placed in a computer operator training program. Since leaving military service, he had worked for 6 years as a grocery clerk until he quit that job to accept employment as a school crossing guard. He held that job for 3 years until the school eliminated his position because of funding restraints. He quit the training program when he obtained employment as a postal clerk.
- Four veterans with minor service-connected disabilities dropped out of training, but records did not show whether the veterans returned to work. For example, one veteran (10 percent rating for a knee condition that had not worsened since he left military service in 1974) worked as a truck driver from 1974 to 1977, went to school between 1977 and 1980 and returned to work for the same employer from 1980 to 1985 as a fork lift operator. He told VA personnel that he quit that job because his leg bothered him when he shifted the forklift gears. Without contacting the veteran's employer, the VA counselor determined that the veteran needed rehabilitation training to become an insurance adjuster. The veteran dropped out of the training program after only 4 months but the files did not show whether the veteran returned to work.

Although these veterans had substantive employment histories when they applied for vocational rehabilitation training, counseling psychologists did not contact any current or former employers as required by VA policy to determine whether the veterans' service-connected disabilities contributed to loss of employment or would have hindered retention in current jobs. Since many of these veterans were working or obtained jobs without using the VA training, we believe the counseling psychologists may have found that the veterans did not need rehabilitation training or that they needed employment services only.

e. Not All Veterans Were Placed In Training Programs That Were Compatible With Their Disabilities Or Consistent With Their Interests, Aptitudes and Abilities

In 31 of the 130 cases reviewed, we found that counseling psychologists placed veterans in training programs that were incompatible with their disabilities or inconsistent with their abilities, aptitudes, or interests. Three examples follow:

- One veteran who wanted vocational training was placed in a college level course. The veteran never attended classes, returned his subsistence checks, and stated that he would like to return to training, but not in a college course. This veteran was placed in a program that was not consistent with his interests.

- A veteran whose aptitude tests indicated that he had lower than average mental ability, and who had failed in his previous attempt to complete college level courses in accounting, was placed in the same college degree program. He dropped out after one semester due to unsatisfactory progress. This veteran was placed in a program that was not consistent with his aptitudes.

- One veteran whose service-connected disabilities prevented him from working in hot, toxic, and dirty conditions was placed in a training program to become a welder.

Twenty of the 31 veterans who, in our opinion, were placed in unsuitable programs had already dropped out of training at the time of audit.

f. Analysis Of Military Retirees In Rehabilitation Training

Most military retirees did not require or use the rehabilitation training they received. Our review included 19 veterans who had retired from the military with at least 20 years of active service and who were not retired as a result of their service-connected disabilities. Our analysis of the 19 cases showed:

- Six of eight retirees who completed their training programs did not obtain employment consistent with their training. Three chose not to seek employment and three found jobs on their own that were unrelated to their training.
- Three of four retirees who quit training were employed or obtained employment during training that was unrelated to their rehabilitation program.
- Five of seven retirees who were still in training were already employed when approved for training and were continuing to work at the time of audit.

To illustrate, one retiree worked as an administrative officer for 11 years prior to retirement, retired after 22 years active duty, and received $1100 per month retired pay. His service-connected disability was for hypertension (10 percent) that had been controlled by medication for more than 2 years before retirement. He enrolled in the university of his own choice and obtained employment with that university prior to beginning rehabilitation training. He was promoted to Food Service Director at the university 2 years before completing his training program (a job where he supervised 110 employees and earned $18,000 per year). The veteran completed his training program (Director of Religious Education) that took 4½ years and cost the VA about $33,000. He continued his employment in the same job at the university after training. In total, only 2 of the 19 military retirees completed their training programs and obtained employment consistent with that training.

In our opinion, there are additional factors that are unique to military retirees that should be carefully considered before authorizing training. Some of these factors are: (i) veterans have successfully completed one career and have job skills that could be transferable to civilian employment; and (ii) these veterans have retirement income and they may not need or want to work. Considering these unique conditions and the results of our audit analysis, we believe that Regional Office personnel should be provided more specific guidance concerning the approval of military retirees for vocational rehabilitation training.

g. Cost Of Unneeded or Inappropriate Training

In our opinion, 65 of the 130 veterans included in the audit received unneeded or inappropriate rehabilitation training. Since these cases were selected at random, we believe our audit results are representative of the entire program. Program costs for 130 veterans audited was $624,678, and program costs for the 65 veterans we questioned was $266,051

(43 percent). Accordingly, we estimated that program funds of about $45 million annually were spent for unneeded or inappropriate training ($105 million X 43 percent).

h. **Conclusion**

Program expenditures on 50 percent of the veterans included in the audit did not have an identifiable impact on their employability. The veterans who had jobs kept those jobs and other veterans with substantive employment histories quit the program when they found jobs on their own. Some veterans appeared to be unemployed by choice since the files did not show that reasonable effort had been made to obtain employment.

CHIEF BENEFITS DIRECTOR'S COMMENTS

Agree with all recommendations.

Implementation Plan

Revised instructions on the initial evaluation process are in development and should be issued to field staff in a manual chapter by June 30, 1988.

Excerpts Of Chief Benefits Director's Comments

The full text of the Chief Benefits Director's comments is in the Appendix. Although he agreed with each recommendation, these excerpts are considered particularly pertinent to the discussion portion of this finding.

On page 4 of the report various policy issues are cited. From these citations the report quotes requirements and concepts critical to the initial evaluation process and draws conclusions that these requirements were not properly met in a significant number of cases. These concepts are complex and are generally considered to be issues which do not lend themselves to absolute or definitive "yes" or "no" answers. From experience, we know that it is difficult to make meaningful evaluations of eligibility and entitlement based on a written record which may not fully document the information development/decision-making process that occurs between a counseling psychologist and veteran.

On page 7 of the report, the audit staff draw certain conclusions relative to the apparent interest of veterans to obtain employment or their ability to retain current employment. These two points are critical for the understanding of the vocational rehabilitation program.

First, if a veteran presents himself/herself as interested in gaining employment as the goal of a vocational rehabilitation program, there is no authority granted to the Veterans Administration to question this intention. We must take statements of interest at face value. Second, the fact that a veteran may be employed at the time of application for vocational rehabilitation services is not evidence that this employment is suitable.

The report states that counseling psychologists placed 31 veterans in training programs that appeared to be incompatible with their disabilities or were inconsistent with their abilities, aptitudes, and interests. Our review of these cases did not substantiate the audit staff's findings.

The report singles out military retirees as a group that did not require or use the rehabilitation training they received. The audit staff go on to suggest that these veterans have retirement income and they may not need or want to work. The criteria for eligibility and entitlement to the VA's program of vocational rehabilitation includes an assessment of income as part of the evaluation of suitable employment. If a veteran is otherwise eligible and entitled to services and indicates that he or she is interested in employment, the expression of intent must be taken at face value.

OFFICE OF INSPECTOR GENERAL COMMENTS

The implementation plan is acceptable and these issues are considered resolved.

The following comments pertain to excerpts from the Chief Benefits Director's comments.

We agree that requirements and concepts involved in the initial evaluation process are complex and do not always lend themselves to "yes" or "no" answers. However, we do not agree that counseling psychologists should commit the Government to providing costly assistance to veterans based on statements of interest taken at "face value". VA policy requires that eligibility and entitlement decisions be based on facts that are clear, specific, and convincing. Statements taken at "face value" do not satisfy this policy requirement and additional development of such cases should be initiated.

We agree that being employed is not evidence that veterans' employment is suitable. However, our analysis showed that veterans continued to work in jobs that counseling psychologists concluded were unsuitable, even though these veterans successfully completed training for different vocations. We believe program managers need to analyze and evaluate such trends.

Management stated that their review of cases did not substantiate that veterans were placed in training programs that appeared to be incompatible with veterans' disabilities or that were inconsistent with the veterans' abilities, aptitudes and interests. During the audit, we referred such cases for review and program staff agreed with our findings in some cases. In several other cases, program staff responded that they were unable to agree or disagree with the suitability of the selected training program because the case files and counseling folders lacked sufficient documentation.

2. The Success Rate Was Low For The Vocational Rehabilitation Program

Finding

The VA expended about $125 million annually for its vocational rehabilitation program, but only about 6 percent of the 27,000 veterans who participated were rehabilitated. The audit disclosed that Regional Office personnel did not: (i) accurately report the number of rehabilitated veterans; (ii) provide adequate assistance in obtaining suitable employment; (iii) continue employment services until rehabilitation was achieved; (iv) monitor program results and cost effectiveness; and (v) identify trends contributing to the high percentage of veterans who participated but were not rehabilitated. Consequently, the VA vocational rehabilitation program was not sufficiently effective and was not economically accomplishing its intended purpose of rehabilitating veterans.

Recommendation 2

We recommend that the Chief Benefits Director:

a. Issue specific guidance regarding conditions that must be met before reporting veterans as rehabilitated and hold training sessions with Regional Office personnel to ensure accurate reporting of program results.

b. Direct full implementation of the employment assistance services provision of public law.

c. Continue employment services until rehabilitation is achieved in accordance with established policy.

d. Coordinate with Federal and State vocational program officials to identify trends contributing to their substantial success rates.

e. Establish a specific program success rate as a goal to encourage Regional Office personnel to increase program successes.

f. Establish internal control procedures to ensure that essential program data are accurately input into the reporting system and used to monitor and evaluate program results and effectiveness.

g. Establish procedures to identify program managers with minimal program successes for specialized training.

Discussion

a. Background

Title 38, United States Code, Section 1500 provides that the purpose of vocational rehabilitation training is to enable veterans with service-connected disabilities that cause employment handicaps to become employable and to maintain suitable employment.

Guidance contained in Title 38, Code of Federal Regulations, paragraph 21.196 provides that veterans are considered rehabilitated when suitable employment is obtained and maintained for at least 60 days and employment is:

- consistent with the objective for which rehabilitation training was provided or in another field with commensurate wages and benefits;
- consistent with the veterans' abilities, aptitudes, interests and the limiting effects of their disabilities.

Title 38, United States Code, Section 1517 provides that veterans with service-connected disabilities who have participated in vocational rehabilitation programs and the Administrator has determined to be employable shall be helped in obtaining suitable employment by providing assistance such as: (i) direct placement in employment; (ii) use of services of disabled veterans outreach program specialists; and (iii) use of job development and placement services of (a) programs under the Rehabilitation Act of 1973; (b) the State employment service and the Veterans' Employment Service of the Department of Labor; (c) the Office of Personnel Management; and (d) any other public or nonprofit organization having placement services available.

b. Program Success Rates Were Overstated

Regional Office personnel reported that veterans were rehabilitated although they did not need rehabilitation training or did not obtain suitable employment as a result of training provided by the VA. We randomly selected for review 72 of the 3,440 veterans reported as rehabilitated during the year ended February 1986.

We questioned whether 45 of the 72 veterans reported as rehabilitated were actually rehabilitated. In our opinion, the 45 veterans should not have been reported as rehabilitated for these reasons: (i) veterans did not obtain employment consistent with their training; (ii) veterans did not obtain suitable employment; (iii) veterans did not need rehabilitation training; (iv) veterans did not obtain and retain jobs for 60 days; and (v) veterans received no training or services. Five veterans were included in 2 of the above categories, therefore the details that follow identify a total of 50 veterans.

Twenty-one veterans did not obtain employment consistent with the objective of their rehabilitation training program or in an occupation with commensurate wages and benefits. The jobs they obtained had no relationships to the training they received. For example, a veteran was trained to become a computer programmer, however, he was reported as rehabilitated based on employment as a seasonal lawn worker. See Exhibit 3 for details of the 21 veterans.

Thirteen veterans should not have been reported as rehabilitated because the employment they obtained was not suitable. VA policy contained in Department of Veterans Benefits Manual M-28-1, Part I, Chapter 5 provides that veterans were not suitably employed if they:

- were employed in a job that was not compatible with the limitations imposed by their service-connected disabilities.
- were not adequately trained to do their jobs.
- held seasonal employment.

For example, one veteran, who worked as a welder for 20 years after his discharge from the military, was trained to be an electronics technician because he stated that his service-connected disability prevented him from standing for prolonged periods of time. After completing the 23-month training program, the veteran was reported as rehabilitated when he resumed employment as a welder. Another veteran was reported as rehabilitated 37 days after he obtained an on-the-job training position as a warranty claims clerk. He was subsequently terminated for unsatisfactory work prior to completing the on-the-job training. We question the appropriateness of reporting these veterans as program successes.

Seven veterans should not have been counted as program successes because they did not need rehabilitation training since they had already prepared for and obtained employment on their own and the files did not show that their service-connected disabilities would prevent them from retaining those jobs. For example, one veteran was employed as a corrections officer for 2 years when he applied for rehabilitation training. There was no evidence in the file showing that the veteran's service-connected disability was hindering retention in that job. The files showed that he enjoyed his work as a corrections officer and planned to remain at that job after obtaining his degree. When the veteran was promoted to the position of corrections case manager, the rehabilitation plan was changed to show that his program goal was to become a corrections case manager and the veteran was declared rehabilitated based on that job. These seven veterans worked for the same employer before, during and after training.

Five veterans who did not obtain and retain jobs for 60 days were counted as program successes. For example, a 66 year-old veteran, who retired from the military in 1967 after 22 years of service and also retired from a GS-9 civil service job in 1981, was trained to be a self-employed small engine repairman. The veteran completed the 21-month training program at a cost of about $13,000. When the VA case manager reported this veteran as a program success, he commented:

> "This is an independent instructor program. Veteran is 66 years of age with a 60% disability. He reflects no motivation towards his own shop operation or full-time employment. Some part-time seasonal work is foreseen. Further followup is not necessary as it will be a waste of time and effort."

Four veterans who received no rehabilitation training or services were reported as program successes. For example, one veteran who the counselor determined did not need training and who received no employment assistance was counted as a program success after he obtained employment on his own. In the other instances, two veterans who were reported as rehabilitated in 1976 and one veteran in 1978 were counted as 1985 program successes due to clerical errors.

Vocational Rehabilitation program management officials in VA Central Office reviewed all cases we questioned and agreed that 37 of the 45 veterans should not have been reported as rehabilitated. Program officials maintained that the remaining eight veterans were successfully rehabilitated. Although we continue to question these cases, we removed them from our projections. A significant error rate still resulted. Only 35 (including the 8 questionable successes) of the 72 veterans (49 percent) needed vocational rehabilitation training, completed their approved program, and obtained suitable employment consistent with the objectives of their training. Based on these results, we estimated that about 1,700 veterans (3,440 x 49 percent) were properly reported as rehabilitated during the year. To compute an annual rehabilitation rate, the number of veterans who exited the program during the same year without being rehabilitated would have to be known. However, VA reports did not accumulate this data and program officials could not obtain such figures. In the absence of actual data, we used the 27,000 participants during 1985 to compute a success rate of about 6 percent for that year (1,700 divided by 27,000). We believe that our computation is reasonable since the number of program participants during each year had remained relatively constant since 1977.

c. Employment Services Usually Were Not Provided

Many veterans were not provided assistance from the VA in obtaining employment. We reviewed counseling records to determine the nature of employment services provided to veterans once they completed their training programs. In making this review we used the same procedures that are used by VA program managers making quality assurance reviews. We found no evidence that employment assistance services were provided to 44 of the 72 veterans reviewed. The other 28 veterans received assistance (some received more than one service) as shown below:

- fifteen were referred to state or local job services;
- fourteen were provided information on possible employers;
- ten were referred to employers with available jobs;
- seven were assisted in preparing their resumes;
- four were assisted in completing job applications; and,
- four were trained to interview for a job.

Employment services were discontinued for veterans who did not obtain suitable employment. Once a veteran was reported as rehabilitated, employment assistance services were discontinued. We found that 36 veterans whose employment services were discontinued should not have been considered rehabilitated. Twenty-five of these veterans received no employment assistance. None of the five veterans who were unemployed when they were declared rehabilitated received any employment services.

d. Comparison of Program Results Between VA and State Vocational Rehabilitation Programs

Since VA personnel had not established specific criteria for measuring program effectiveness, we compared VA and State programs and found that the VA program success rate and cost effectiveness were significantly less than State programs. We recognize that all aspects and services of both programs are not identical, but the objectives of these programs are the same. Both vocational training programs require persons to have employment handicaps and obtain suitable employment for at least 60 days before being declared rehabilitated.

The data obtained from the U.S. Department of Education showed that the State vocational rehabilitation programs provided services for more persons with serious employment handicaps, rehabilitated a significantly higher percentage of clients, including those with serious employment handicaps, and had a much lower cost per rehabilitated client than the VA program. The details of this analysis were provided to program officials during the audit. In the absence of specific program results criteria, it is our opinion that this comparison provides reasonable indications as to whether VA program results were sufficiently effective.

We believe that the data from similar programs showed that the VA vocational rehabilitation program can achieve a better success rate and increase its cost effectiveness.

e. Program Results And Cost Effectiveness Were Not Properly Monitored And Analyzed

Regional Office personnel did not assess program results and cost effectiveness. VA policy contained in Department of Veterans Benefits Circular 20-84-20 requires that internal controls be established to ensure that VA managers carry out their duties in a responsible manner and are held answerable for success or failure. The policy lists the specific program areas requiring internal control reviews, but does not require the establishment of internal controls to monitor management's success in accomplishing the purpose of the vocational rehabilitation program, as we believe it should. VA program managers did not set goals for program success, consequently, Regional Office and Central Office personnel could not evaluate performance to determine whether it should or could be improved. In addition, Regional Office personnel were not required by Department of Veterans Benefits Manual 28-3 to analyze program success as part of the quality assurance review. In our opinion, this should be an essential element of quality assurance reviews.

Program reports contained insufficient and inaccurate data. For example, our audit disclosed erroneous or no data in the Vocational Rehabilitation computer master record regarding the number of veterans with serious employment handicaps participating in the program. Program officials were not able to furnish this data.

f. Conclusion

Based on the audit results, we estimated that only about 6 percent of program participants were rehabilitated. Although the success rate was low, we found no evidence that VA personnel attempted to identify trends contributing to the high percentage of veterans who participated but were not rehabilitated. Making VA managers accountable for program success and setting reasonable goals would provide incentive for them to identify ways to improve the services provided to program participants. Providing accurate program data would assist managers in assessing program results.

CHIEF BENEFITS DIRECTOR'S COMMENTS

Agree with all recommendations.

Implementation Plan

A circular addressing conditions that must be met before reporting veterans as rehabilitated and continuing employment services until rehabilitation is achieved has been issued and staff training has occurred with all field staff.

A task force of VR&C staff and other appropriate members has been established to determine how best to promote effective and efficient employment services in the Chapter 31 program. Recommendations from this group are expected by March 30, 1988.

Coordination with program officials and data collection will occur by March 31, 1988.

A pilot program of program evaluation will be implemented by March 31, 1988. The program evaluation system will include elements such as rehabilitation closures, but will also assess other pertinent program aspects.

A new system of quality review will be field tested in 1988. This test should begin by March 30, 1988.

Field survey criteria have been modified to place appropriate emphasis on identifying program managers with minimal program successes.

Excerpts Of Chief Benefits Director's Comments

The full text of the Chief Benefits Director's comments is in the Appendix. Although he agreed with each recommendation, these excerpts are considered particularly pertinent to the discussion portion of this finding.

The report has reduced the number of rehabilitations on the basis that some of these persons should not have been found entitled to a program of services because of a misunderstanding by the IG of Title 38 requirements and official VA policy.

At the request of IG staff, program staff in Central Office reviewed 45 cases in which the IG felt that declarations of rehabilitation had not been made in accordance with the criteria found in regulations. Program staff did agree that 37 of the 45 contained errors. Since this trend has never appeared in field station or Central Office case reviews, program staff issued a circular to the field staffs clarifying policy on declarations of rehabilitation. Because it was felt that the sample obtained by the IG was not representative, program staff undertook a review of cases declared rehabilitated over a 6-month period. In a review of over 700 cases, an error rate of 15 percent was found. While this is an unacceptable error rate, it more closely approximates prior quality review findings.

While both the VA and state-federal programs provide services and assistance to disabled persons, there are significant differences in their clients which make comparison difficult. A greater proportion of participants in the state-federal program are either younger and dependent on others for support, or older than chapter 31 participants. While almost all veterans in the VA program receive vocational training services, only about half of the veterans rehabilitated under the state-federal program have received any training services.

While both programs are committed to special efforts in behalf of persons with serious disabilities, the determination that a person is seriously disabled is quite different. Under the state-federal program, an individual may be found to be "severely handicapped" by virtue of a specific diagnosis. Under the VA program, there is a special focus on the veteran's service-connected disability in reaching this decision. The differences between decisions are due to differences in the process of determining serious disability which reflect the mission of both programs. When these differences in the process are considered, all that can reasonably be said is that both programs make special efforts to identify and provide rehabilitation services to persons with serious disabilities in a manner consistent with their program mission.

When the various factors are considered, it is easily seen that the main sources of differences in cost stem from differences in program mission, scope and nature of services provided, population served, and such structural factors as the longer duration of VA programs and payments of monthly monetary benefits in the form of subsistence allowance which are not provided under the state-federal program. These differences significantly reduce the extent to which the two programs can be validly compared. Rather, evaluation of cost effectiveness requires that the goals of each program be considered in terms of its objectives and goals and the extent to which these objectives are economically and efficiently achieved within the structure of the program determined. Efforts to evaluate the extent to which these goals are accomplished under the VA program are underway through a comprehensive program evaluation study conducted by the VA's Office of Program Analysis and Evaluation.

The report suggests that program analysis does not exist in assessing program results. It is apparent that the audit did not examine the program of systematic analyses of operations which includes reviews of discontinued veterans. These reviews are designed to examine the reasons why veterans exit from the program. While case managers encourage veteran participants to complete their programs and obtain suitable employment, veterans have the right of self-determination.

OFFICE OF INSPECTOR GENERAL COMMENTS

The implementation plans are acceptable and these issues are considered resolved.

The following comments pertain to excerpts from the Chief Benefits Director's comments.

Concerning management's contention that our sample of rehabilitated veterans was not representative, we point out that our sample cases were selected at random by computer and program officials agreed that 37 of the 72 cases contained errors. We estimated based on the audit results that as many as 1,700 veterans were rehabilitated during the year, or over 50 percent less than the 3,440 reported. As a result of the audit, management provided field staff members with revised instructions specifying conditions required to be considered rehabilitated and made a 100-percent review of each veteran's case during the 6 months ended September 30, 1987. This review found that only about 600 veterans were properly reportable as rehabilitated based on established criteria. Projecting those results to an annual basis shows that about 1,200 veterans would be considered program successes. Based on these results, we believe that our sample was representative and that our annual estimate of rehabilitated veterans was reasonable.

Our report recognizes that all aspects and services of state and VA vocational rehabilitation programs were not identical.

Our point concerning program analysis was not that no analysis was being done, but that more specific analysis and internal controls were needed to monitor program success and cost effectiveness.

3. Employment Adjustment Allowance Payments Were Not Always Appropriate

Finding

Veterans were paid employment adjustment allowances although they did not complete an approved rehabilitation training program or they were employed before completing rehabilitation training. This condition was caused by inadequate policy guidance and inconsistent interpretations of existing policy. As a result, we estimated that annual payments of about $667,000 could be avoided.

Recommendation 3

We recommend that the Chief Benefits Director issue specific policy directives to preclude routine payment of employment adjustment allowances to veterans who do not complete their approved training program or who were employed in the same job during training.

Discussion

a. Background

Title 38, United States Code, Section 1508 (a) (2) provides guidance concerning employment adjustment allowances:

> "In any case in which the Administrator determines, at the conclusion of such veteran's pursuit of a vocational rehabilitation program under this chapter, that such veteran has been rehabilitated to the point of employability, such veteran shall be paid a subsistence allowance, as prescribed in this section for full-time training for the type of program that the veteran was pursuing, for two months following the conclusion of such pursuit."

Title 38 defines the term "rehabilitated to the point of employability" as meaning "...employable in an occupation for which a vocational rehabilitation program has been provided under this chapter."

In implementing Title 38, the VA issued guidance in Department of Veterans Benefits Circular 28-80-3 clarifying the changes in procedures for processing employment adjustment allowance payments. This guidance establishes "...the role of the benefit as an aid in the transition into the work environment..." and the Circular was clarified to "...clearly indicate that the veteran is not rehabilitated when he or she receives this 2-month benefit..."

b. **Payments Were Not Always Consistent In Similar Cases**

Veterans who were reported as rehabilitated were not always authorized the allowance. We identified 17 veterans who did not complete an approved rehabilitation training program, but were reported as rehabilitated because they found employment on their own. In 10 of the 17 cases, Regional Office personnel did not authorize payment of the allowance because the veteran did not complete an approved rehabilitation training program. In our opinion, this action was consistent with Title 38 criteria. Conversely, the audit identified 7 veterans who also did not complete their approved rehabilitation programs but, unlike the other 10 veterans, were paid the allowance. For example, one veteran attended training for about 3 months and dropped out without notifying the VA. During a routine followup review, Regional Office personnel became aware that the veteran had obtained employment on his own, and 3 months later, authorized the 2-month allowance effective on the date that the veteran would have completed his approved training program.

c. **Payments Were Made to Veterans Who Were Already Employed**

Regional Office personnel authorized payment of the allowance to 11 veterans although they were already employed before completion of their approved rehabilitation training programs. Five of the 11 veterans were employed by the same employer before, during and after rehabilitation training. Two examples follow:

- A veteran began working with the Veterans Service Division in a VA Regional Office about 1 month after his release from active duty in February 1974. He continued working full time with the VA Regional Office during the 10 years it took him to complete an associate degree in business. Regional Office personnel authorized payment of a $970 employment adjustment allowance in January 1985, although the veteran was a GS-9 veterans benefits counselor, had been employed with the VA for about 10 years and continued employment with the VA after completing his training program.

- A 64-year old veteran who was self employed (selling his artwork) completed 10 college courses in silversmithing, photography, Indian art and oil painting. He was selling arts and crafts before, during and after this training. Regional Office personnel authorized payment of a $768 employment adjustment allowance.

d. **Computation Of Cost Efficiencies**

The audit identified inappropriate payments to 16 of the 72 veterans reviewed (22.2 percent). Two veterans were included in both categories discussed. Since these cases were selected at random, we believe our results are representative of all cases. Overall, we estimated that 764 veterans (3,440 X 22.2 percent) inappropriately received payments during the year ended February 1986. The average payment to the 16 veterans was $873. Accordingly, we estimated that annual payments of about $667,000 could be avoided.

e. **Conclusion**

Title 38 authorizes the Administrator to determine those cases of veterans who should be paid an employment adjustment allowance. Existing policy directives are vague and can be and have been interpreted that the allowance can be paid in almost any circumstance. As a result, payments were made to veterans who did not need the allowance for "...transition into the work environment" and payments were made to veterans at one Regional Office that were denied at other Regional Offices. Specific criteria need to be established to preclude routine payment of this allowance.

CHIEF BENEFITS DIRECTOR'S COMMENTS

Disagree. The recommendation, as worded, is too restrictive and is in direct conflict with law. Under certain conditions a veteran who has not completed the plan or services may be determined to have been rendered employable, and therefore eligible for payment of the employment adjustment allowance. For example, a veteran may be declared rehabilitated to the point of employability if he or she leaves the program, but has completed a sufficient portion of the services to establish clearly that he or she is generally employable as a trained worker in the occupational objective or if he or she has not completed all prescribed services, accepts employment in the occupational objective with wages and other benefits commensurate with wages and benefits received by trained workers. A veteran in a program of on-job training who was determined to be rehabilitated to the point of employability would be eligible for such payment.

The responsibility of the VR&C Service in administering the vocational rehabilitation program is to assure that payments are made in accordance with the provisions of 38 CFR 21.190(d). Our review indicates that these payments are being made in conformity with these provisions. The payments of employment adjustment allowance in the cases cited in the text are also correctly made under these regulatory provisions.

Implementation Plan

Program staff are examining the provision of employment services and payment of the employment adjustment allowance. This examination will likely result in adjustments of policy, and possibly, recommendations for legislative or regulatory change in this area.

OFFICE OF INSPECTOR GENERAL COMMENTS

Although management disagreed with the finding and recommendation, the implementation plan provided is acceptable. However, this issue will be considered unresolved until the planned examination is completed and the results reviewed by the Office of Inspector General.

We are aware that existing policy permits payment of employment adjustment allowances to veterans who do not complete their approved programs, but are declared rehabilitated because they were employed as a trained worker in the occupational objective or accepted employment in the occupational objective with wages and other benefits commensurate with wages and benefits received by trained workers. However, during this audit, VA Central Office personnel reviewed 6 of the 7 cases of veterans who dropped out of the program but were paid the allowance. In all cases, they agreed that these veterans should not have been reported as rehabilitated based on applicable VA criteria.

Concerning payments to persons who were employed in the same job during training, we agree that veterans who successfully complete an approved on-the-job training program would be eligible for payment of the allowance. This report has been adjusted to exclude veterans who were in such programs.

If the examination concludes that legislative change is necessary to preclude payment of the allowances to veterans as identified in this report, we believe that such an initiative should be taken.

B. Compliance And Internal Controls

Our audit showed an adequate level of compliance with laws and regulations, and internal controls were found to be appropriate and were operating in a satisfactory manner, except in those areas included in Section A and Exhibit 1 of this report. Nothing came to our attention that would indicate that untested items were not in compliance with applicable laws and regulations.

EXHIBIT 1

COMPLIANCE AND INTERNAL CONTROL EXCEPTIONS

Description of Law, Regulation or Control	Size of Test	Exceptions Number	Exceptions Percent	Internal Control Issue?	Impact	Location	Management Action
1. 38 USC 1502 requires that a veteran must be unable to prepare for, obtain or retain employment consistent with his abilities, aptitudes and interests in order to receive rehabilitation training.	130	65	50	Yes	Major	Vocational Rehabilitation and Counseling Division	In process
2. 38 CFR 21.196 requires that suitable employment must be obtained and maintained for at least 60 days before a veteran is declared rehabilitated.	72	37	51	Yes	Major	Vocational Rehabilitation and Counseling Division	In process
3. 38 USC 1508(a)(2) provides for the payment of employment adjustment allowances.	72	16	22.2	Yes	Major	Vocational Rehabilitation and Counseling Division	Being reviewed

EXHIBIT 2

REGIONAL OFFICES INCLUDED IN THE AUDIT AND NUMBER OF CASES REVIEWED

Regional Office	Cases Reviewed Rehabilitated Veterans	Active Participants	Total
Albuquerque		1	1
Atlanta	2		2
Boston		3	3
Buffalo	4	2	6
Denver	2		2
Des Moines		3	3
Detroit	6	10	16
Fargo		2	2
Ft. Harrison		2	2
Hartford		1	1
Honolulu		2	2
Indianapolis		6	6
Jackson	2	2	4
Lincoln	4		4
Little Rock	6	4	10
Los Angeles		9	9
Louisville		2	2
Milwaukee	2	6	8
Montgomery	6	14	20
Muskogee	5	4	9
Nashville	5	3	8
New Orleans	2		2
New York City	2	5	7
Newark	3	1	4
Philadelphia	3		3
Pittsburgh		3	3
Portland	2		2
Reno		6	6
Roanoke	2	6	8
San Diego	7	5	12
San Francisco	3		3
St. Louis		4	4
St. Paul		2	2
St. Petersburg		2	2
Waco	4	4	8
Washington		8	8
Winston Salem		8	8
Total Veterans	72	130	202
Total Regional Offices	20	30	37

EXHIBIT 3

EMPLOYMENT THAT WAS NOT CONSISTENT WITH THE OBJECTIVE OF REHABILITATION TRAINING

Training Objective	Job Obtained
Accountant	Postal Clerk
Assembler	Housekeeper
Business Manager	Postal Clerk
Computer Operator	Trainee Claims Clerk
Computer Programmer	Seasonal Lawn Worker
Computer Programmer	Factory Worker
Computer Programmer	Postal Carrier
Computer Technician	Postal Clerk
Director of Religious Education	Food Service Director
Doctor of Medicine	Pharmacy Technician
Electronics Mechanic	Custodian
Electronics Technician	Welder
Health Technician	Security Guard
Jewelry Repairman	Custodian
Journalist	Postal Clerk
Office Manager	Postal Clerk
Parts Specialist	City Inspector
Refrigeration Mechanic	Maintenance Man
Restaurant Manager	Television Salesman
Social Worker	Instrument Checker
Teacher	Administrative Assistant

Veterans
Administration

Memorandum

Date DEC 21 1987

From Chief Benefits Director (226)

Subj Draft Report of Audit -- Vocational Rehabilitation Program
(Project 6R6-108)

To Inspector General (52)

1. We appreciate the opportunity to review the draft report of audit for the Vocational Rehabilitation Program. We have been able to concur in 11 out of 12 of the recommendations, but we do take issue with the supporting statements, statistics, interpretation of laws, regulations, and program policy that exist in the text. We do not concur that the nature and degree of concerns exist at the level indicated by the audit staff. We have included, here, comments concerning the findings, conclusions, and recommendations.

2. RECOMMENDATION 1.a. "Require counseling psychologists to comply with existing procedures by contacting current or former employers of veterans with substantive employment histories to determine whether service-connected disabilities were contributing factors to loss or retention of employment."

RESPONSE: Agree

IMPLEMENTATION PLAN: Revised instructions on the initial evaluation process are in development and should be issued to field staff in a manual chapter by 6/30/88.

COMMENTS: The counseling psychologist is required to consider a number of factors in this determination, including whether or not the veteran has been able to overcome his/her impairment to employability through employment in an occupation consistent with his or her abilities, aptitudes and interests. This issue is far more complex than simply attempting to determine whether or not the veteran's service-connected disability caused a termination of employment. Contacting a current or prior employer depends on the nature of the specific case and must be done cautiously to avoid complications for the veteran.

3. RECOMMENDATION 1.b. "Establish policy requiring that employment services be provided before attempting retraining of veterans whose service-connected disabilities did not prevent them from obtaining or retaining past [suitable] employment."

RESPONSE: Agree

IMPLEMENTATION PLAN: Revised instructions on the initial evaluation process are in development and should be issued to field staff in a manual chapter by 6/30/88.

COMMENTS: Effective policy and procedures currently exist and allow for a program of employment services when the counseling psychologist determines that a veteran does not require education and training to prepare for suitable employment, but only requires employment assistance to obtain or retain suitable employment. While the recommendation does not use the term "suitable employment", we assume that this was an omission and that the criteria for determining suitable employment, as described in regulations, is clearly understood by the audit staff.

4. RECOMMENDATION 1.c. "Notify counseling psychologists that more emphasis needs to be placed on documentation of past employment, prior academic work and veterans' abilities, aptitudes and interest when making eligibility determinations and identifying vocational rehabilitation training to be recommended for veterans."

RESPONSE: Agree

IMPLEMENTATION PLAN: Revised instructions on the initial evaluation process are in development and should be issued to field staff in a manual chapter by 6/30/88.

COMMENTS: Established policy requires a complete evaluation of all applicants. This includes an assessment of the individual's prior developed knowledges and skills and how they might be considered in making the decisions required for entitlement and program planning. This policy will be reaffirmed with the program manuals now in the concurrence process.

5. RECOMMENDATION 1.d. "Reconfirm established policy that unique factors concerning military retirees must be carefully considered before authorizing entry into vocational rehabilitation training by veterans who retired with 20 or more years of active service."

RESPONSE: Agree

IMPLEMENTATION PLAN: Revised instructions on the initial evaluation process are in development and should be issued to field staff in a manual chapter by 6/30/88.

3.

Inspector General (52)

5. ADDITIONAL COMMENTS ON PART I: On page 4 of the draft report, under the heading "Background", Title 38, Code of Federal Regulations, section 21.51 and various policy issues are cited. From these citations the report quotes requirements and concepts critical to the initial evaluation process and draws conclusions that these requirements were not properly met in a significant number of cases. These concepts are complex and are generally considered to be issues which do not lend themselves to absolute or definitive "yes" or "no" answers. From experience, we know that it is difficult to make meaningful evaluations of eligibility and entitlement based on a written record which may not fully document the information development/decision-making process that occurs between a counseling psychologist and veteran.

On page 7 of the draft audit report, the audit staff draw certain conclusions relative to the apparent interest of veterans to obtain employment or their ability to retain current employment. These two points are critical for the understanding of the vocational rehabilitation program. First, if a veteran presents himself/herself as interested in gaining employment as the goal of a vocational rehabilitation program, there is no authority granted to the Veterans Administration to question this intention. We must take statements of interest at face value. Second, the fact that a veteran may be employed at the time of application for vocational rehabilitation services is not evidence that this employment is suitable, using the criteria of our regulations. Our cases are full of examples where veterans are employed in jobs which are aggravating their disabilities, but employment is maintained because of their income needs. VR&C staff are required to assess the current functional limitations of disability and determine if the shown employment handicap has been overcome by the preparation or actual employment in a suitable occupation.

The report states, "In 31 of 130 cases reviewed, we found that counseling psychologists placed veterans in training programs that appeared to be incompatible with their disabilities or were inconsistent with their abilities, aptitudes, and interests." Our review of these cases did not substantiate the audit staff's findings.

The report singles out military retirees as a group that "....did not require or use the rehabilitation training they received." All applicants for the chapter 31 program are entitled, by law, to be provided with a comprehensive evaluation to determine if they are in need of rehabilitation services. Military experience, training, and skills are taken into consideration in determining whether the veteran can qualify for suitable employment. The audit staff go on to suggest that "these veterans have retirement income and they may not need or want to work". The criteria for eligibility and entitlement to the VA's program of vocational rehabilitation includes an assessment of income as part of the evaluation of suitable employment. If a veteran is otherwise eligible and entitled to services and indicates that he or she is interested in employment, the expression of intent must be taken at face value.

6. RECOMMENDATION 2.a. "Issue specific guidance regarding conditions that must be met before reporting veterans as rehabilitated and hold training sessions with Regional Office personnel to ensure accurate reporting of program results."

RESPONSE: Agree

IMPLEMENTATION PLAN: A circular addressing this area has been issued and staff training has occurred with all field staff.

7. RECOMMENDATION 2.b. "Direct full implementation of the employment assistance services provision of public law".

RESPONSE: Agree

IMPLEMENTATION PLAN: A task force of VR&C staff and other appropriate members has been established to determine how best to promote effective and efficient employment services in the chapter 31 program. Recommendations from this group are expected by March 30, 1988.

8. RECOMMENDATION 2.c. "Continue employment services until rehabilitation is achieved in accordance with established policy".

RESPONSE: Agree

IMPLEMENTATION PLAN: The circular cited above addresses this issue.

9. RECOMMENDATION 2.d. "Coordinate with Federal and State vocational program officials to identify trends contributing to their substantial success rates.

RESPONSE: Agree

IMPLEMENTATION PLAN: Coordination with program officials and data collection will occur by March 31, 1988.

5.

Inspector General (52)

COMMENTS: While both the VA and state-federal programs provide services and assistance to disabled persons, there are significant differences in their clients which make comparison difficult. A greater proportion of participants in the state-federal program are either younger and dependent on others for support, or older than chapter 31 participants. Younger clientele include persons with developmental disabilities, especially the mildly retarded. Older dependent persons include older women for whom a rehabilitation goal of homemaker is frequently established. There is no comparable rehabilitation category in the VA program. On the other hand, chapter 31 participants are overwhelmingly persons who are the primary wage earners for their families.

While almost all veterans in the VA program receive vocational training services, only about half of the veterans rehabilitated under the state-federal program have received any training services. Other participants in the state-federal program are provided a variety of medical services, primarily restorative services.

While both programs are committed to special efforts in behalf of persons with serious disabilities, the determination that a person is seriously disabled is quite different. Under the state-federal program, an individual may be found to be "severely handicapped" by virtue of a specific diagnosis i.e., retardation, or a finding based on evaluation of the individual's situation. Under the VA program, there is a special focus on the veteran's service-connected disability in reaching this decision. For example, the VA system severely limits the extent to which veterans with service-connected disabilities evaluated at less than 30 percent may be found to have a serious employment handicap, even if the veteran has substantial additional limitations due to non-service-connected disability. This individual would not be found to have a serious employment handicap under the VA program but would be found to be severely handicapped under the state-federal program. The differences between decisions are due to differences in the process of determining serious disability which reflect the mission of both programs. When these differences in the process are considered, all that can reasonably be said is that both programs make special efforts to identify and provide rehabilitation services to persons with serious disabilities in a manner consistent with their program mission.

When the various factors are considered, it is easily seen that the main sources of differences in cost stem from differences in program mission, scope and nature of services provided, population served, and such structural factors as the longer duration of VA programs and payments of monthly monetary benefits in the form of subsistence allowance which are not provided under the state-federal program. These differences significantly reduce the extent to which the two programs can be validly compared. Rather, evaluation of cost effectiveness requires that the goals of each program be considered in terms of its objectives and goals and the extent to which these objectives are economically and efficiently achieved within the structure of the program determined. Efforts to evaluate the extent to which these goals are accomplished under the VA program are underway through a comprehensive program evaluation study conducted by the VA's Office of Program Analysis and Evaluation.

10. RECOMMENDATION 2.e. "Establish specific program success rate as a goal to encourage Regional Office personnel to increase program successes".

RESPONSE: Agree

IMPLEMENTATION PLAN: A pilot program of program evaluation will be implemented by March 31, 1988.

COMMENTS: Program evaluation is much more complex than the establishment of success rates. The program evaluation system which will be piloted in 1988 will include elements such as rehabilitation closures, but will also assess other pertinent program aspects.

11. RECOMMENDATION 2.f. "Establish internal control procedures to ensure that essential program data are accurately input into the reporting system and used to monitor and evaluate program results and effectiveness".

RESPONSE: Agree

IMPLEMENTATION PLAN: A new system of quality review will be field tested in 1988. This test should begin by March 30, 1988.

12. RECOMMENDATION 2.g. "Establish procedures to identify program managers with minimal program successes for specialized training".

RESPONSE: Agree

IMPLEMENTATION PLAN: Field survey criteria have been modified to place appropriate emphasis on this issue.

13. ADDITIONAL COMMENTS ON PART II: In the section titled, "Program Results and Cost Effectiveness Were Not Properly

Monitored and Analyzed", the report suggests that program analysis does not exist in assessing program results. It is apparent that the audit did not examine the program of systematic analyses of operations which includes reviews of discontinued veterans. These reviews are designed to examine the reasons why veterans exit from the program. In the case of veterans who are discontinued, we generally find that the reasons are quite human. Some veterans experience worsening of medical/psychological conditions, some obtain employment which is not considered by case managers to be suitable or consistent with those services provided by the VA, some wish training programs which case managers consider unsuitable, some decide to pursue additional education on their own or through other VA programs such as the GI Bill, and some decide against employment. While case managers encourage veteran participants to complete their programs and obtain suitable employment, veterans have the right of self-determination.

The report has reduced the number of rehabilitations found by VR&C on the basis that some of these persons should not have been found entitled to a program of services. On page 12, the IG report states that "Section 1500 provides that the purpose of vocational rehabilitation training is to enable veterans with service-connected disabilities that cause employment handicaps to become employable and to maintain suitable employment." This section, in fact, states, "The purposes of this chapter are to provide for all services and assistance necessary to enable veterans with service-connected disabilities to achieve maximum independence in daily living, and, to the maximum extent feasible, to become employable and to obtain and maintain suitable employment."

The actual definition differs from the IG's statement in two major respects which are relevant to this discussion. First, the VA is required to expend maximum effort to make the veteran employable. This statement has significant implications for the type of services which are provided to accomplish this objective. Second, the definition in the law does not contain the statement that services are limited to those veterans whose service-connected disabilities cause an employment handicap. Official VA policy, contained in 38 CFR 21.51(b)(2), states, in part, "The veteran's service-connected disability need not be the sole or primary cause of the employment handicap, but must materially contribute to the impairment." This misunderstanding by the IG appears to be the major basis for objecting to findings of both entitlement to services and declarations of rehabilitation policy. At the request of IG staff, VR&C program staff in Central Office reviewed 45 cases in which the IG felt that declarations of rehabilitation had not been made in accordance with the criteria found in regulations. VR&C did agree that 37 of the 45 contained errors. In some cases this was a result of field staff not adequately documenting the case, providing followup to assure the veteran was suitably employed, or making determinations of rehabilitation that did not meet program criteria. Since this trend has never appeared in field station or CO case reviews, VR&C program staff issued a circular to the field staffs clarifying policy on employment services followup and declarations of rehabilitation. In addition, because it was felt tht the sample obtained by the IG was not representative, VR&C program staff undertook a review of cases declared rehabilitated over a 6-month period. In a review of over 700 cases, an error rate of 15% was found. While this is an unacceptable error rate, it more closely approximates prior field and CO quality review findings.

14. RECOMMENDATION 3. "We recommend that the Chief Benefits Director issue specific policy directives to preclude routine payment of employment adjustment allowances to veterans who do not complete their approved training program or who were employed in the same job during training".

RESPONSE: Disagree

COMMENTS: The recommendation, as worded, is too restrictive and is in direct conflict with law. VR&C program staff are examining the provision of employment services and the payment of the employment adjustment allowance. This examination will likely result in adjustments of policy, and possibly, recommendations for legislative or regulatory change in this area.

15. ADDITIONAL COMMENTS ON PART III. The IG recommends VA staff preclude routine payment of employment adjustment allowances to veterans who do not complete their approved training program. The law requires that a veteran who has been rehabilitated to the point of employability shall be paid subsistence allowance at the fulltime rate for two months following the conclusion of such pursuit. The term "rehabilitated to the point of employability", is defined in 38 CFR 21.190(d). These provisions state that a veteran has been rendered employable when he or she has achieved the goals of, and has been provided services specified in the individualized written rehabilitation plan. Under certain conditions a veteran who has not completed the plan or services may be determined to have been rendered employable, and therefore eligible for payment of the employment adjustment allowance. For example, a veteran may be declared rehabilitated to the point of employability if he or she leaves the program, but has completed a sufficient portion of the services prescribed in

the IWRP to establish clearly that he or she is generally employable as a trained worker in the occupational objective established in the IWRP or if he or she has not completed all prescribed services in the IWRP, accepts employment in the occupational objective established in the IWRP with wages and other benefits commensurate with wages and benefits received by trained workers.

The IG staff also recommends we preclude payment of the employment adjustment allowance to veterans who were employed in the same job during training. As indicated above, a veteran is eligible for employment adjustment allowance if he or she has been rendered employable. For example, a veteran in a program of on-job training who was determined to be rehabilitated to the point of employability would be eligible for such payment.

Under the provisions of 38 CFR 21.190(d), payment of an employment adjustment allowance is not routinely made to veterans who do not complete their approved training programs. Payment may be made to veterans who do not complete their approved programs only if they meet the conditions specified in the regulatory provision cited above.

The responsibility of the VR&E Service in administering the vocational rehabilitation program is to assure that payments are made in accordance with the provisions of 38 CFR 21.190(d). Our review indicates that these payments are being made in conformity with these provisions. The payments of employment adjustment allowance in the cases cited in the text are also correctly made under these regulatory provisions.

16. We hope that the comments provided to the draft report will be of assistance to you.

R. J. VOGEL

226/349 JR:jr

THE
PUERTO RICAN
ORGANIZATION OF
REGISTERED NURSING

Statement of
Luis Medina RN BS
National Director
The Puerto Rican Organization of Registered Nursing (PRO-RN)

2300 24th. ROAD SOUTH, # 753, ARLINGTON, VIRGINIA 22206 (703) 892-2267

THE
PUERTO RICAN
ORGANIZATION OF
REGISTERED NURSING

June 20, 1988

Mr. Chairman and Members of the Veterans Affairs Committee, I am Luis Medina, a Registered Nurse employed as a Staff Nurse at the Veterans Administration Medical Center, Washington, D.C. During my employment with the VA I have learned the different aspects of nursing practice and the problems affecting the advancement of the profession. I am involved in developing the interest of nurses in professional organizations as a means of accomplishing unity and support. I am the President of the Puerto Rican Organization of Registered Nursing (PRO-RN). PRO-RN was partly conceived as a response to a TV news segment on the Puerto Rican Nurses employed at the Veterans Administration Medical Center in Baltimore, Maryland. The Puerto Rican Organization of Registered Nursing has been established as a concept in which the Registered Nurse from Puerto Rico realizes the importance that networking has played in our careers. As Registered Nurses from Puerto Rico we felt the need of a professional organization that will assist us in enhancing our professional life through activities regarding education, research and employment. PRO-RN is very concerned with need of the veteran population to received the best quality of care that can be provided by the diverse nursing population employed in the Veterans Administration Hospitals and Clinics across the United States.

PRO-RN is concerned with current public image, legislation that may seriously affect our nursing practice. PRO-RN will work to preserve and improve the image of the professional nurses through professional and legislative activism.

The nursing shortage is a result of the historical perception in what a Registered Nurse fuction is. Nursing today has evolved into a system. A system is a set of components constantly interacting with one another to form a whole that transcends and differs from the sum of its parts. Nursing is a system created by people to serve a purpose. The purpose of nursing has not yet been clearly defined and often changes as a result of the conceptions of people outside the system. This further tends to distract the public as to the exact position the nurse occupies as a health care provider.

From 1945 to the earlys 1960's nurses were portrayed as mothers, after sharing the camaderie of the fighting services and the hardships of the war in equal terms. They went back home to function solely as wife and mother. Career woman sank in prestige

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to the levels of dropouts. By the end of the 1940's the new emphasis on domesticity was apparent everywhere. Nurses where portrayed as sympathetic women. The mother image declined during the mid 1960's. In general women were sensing, as never before, that they had far greater capabilities than were being utilized in the traditional feminine role. By 1966 millions of women had been changed by the movement, but nurses seemed left behind in the media accounts of these developments.

Since 1966 the mother image of the nurse had declined and has been portrayed by the most negative media image since the Charles Dicken's pre Nightingale Sairy Gamp. The nurse as a sex symbol is now the pervasive theme throughout novels and motion pictures. The quantity of nurses characters incorporated into the mass media products each year has continued to decline while in the late 1970's and early 1980's female physicians and other women professionals are accorded all the glamour and heroic proportions that were once accorded to media nurses.

It is my believe that one of the major contibutors to the nursing shortage is the nursing hierachy. Hierarchies are evident in every system, and the nursing system is no exception. The nursing hierarchy is vertical due to the difference of knowledge among its members. The vertical hierarchical pattern of organization originated in the seventeenth century in military organizations and was adopted later by early industrial organizations made up of unskilled workers. Vertical hierarchies within the nursing system often deteriotes into pecking orders as members of the higher levels begin to feel superior to those with the lower rank. This is further compounded when the feeling of superiority is generalized to all areas of decision making instead of to a particular area of expertise. The pecking orders of functions and rank that evolved out of overuse of the vertical hierarchical organization has been divisive to the entire nursing system. This system is designed in a pyramid type of organization composed of the staff nurse, head nurse, nursing coordinator or supervisor, assitant chief and director of nurses. PRO- RN endorses section 9 part C to create new models for delivering patient care that will develop into innovative practice models.

PRO-RN strongly endorses part B of Section 9 of Senate bill 2426, Expanded Role for the Chief Nurse. Nurses in management positions, such as directors of nursing, are often expected to be both managers and leaders. In a hospital the nursing director is given the task of managing the largest subsystem in the organization but is not given the support either from within the nursing system or from the large system. Nurse managers need to develop and refine their management skills and focus in working with the nurses they manage. Nurses neeed to support each other and their managers. The nursing system need to devote more time and energy to risk taking nurse leaders. External forces that are pressing for the balanced and efficient system must be exploded. The chief nurse should not report to the chief Medical Director, since the managing of the nursing services is not a colloborative function between physician and nurses. Many nurses still believe they are primarily accountable to a physician. The nurses is accountable to different groups. He/she is accountable to the patient, to the licensing board that represents society, the profession of nursing, to the employing agency and to other health professionals for the colloborative functions. Nurses, more than other health professionals, have the opportunity to influence the planning and programming of health services, the training of health care workers and other levels of nursing that will enhance and elevate their contribution to the health care system. Nurses should be the coordinator of nursing activities and work as members of the professional team. The role of nurses should eminently be administrative of nursing care, the patient care, except in certain areas such as Internsive Care or Special Units, should be entrusted to auxilliary nursing personnel (LPN,s, NA'S, Nursing Tech, etc.). Nurses can develop expertise in managing this auxilliary nursing personnel into a efficient health care system. The participation of the RN in this innovative development of professional nursing will rise the nursing profession into a role that goes beyond the traditional nursing models designed to maintain the nurse in a dependant position.

Today's nurses are a diverse group of health professionals offering nursing services that are equally diverse. Today's nurse is a highly skilled practitioner whose effectiveness is linked to the acquisition of sound knowledge. The services provided by nursing today are not limited to the hospital setting, home setting, outpatient clinics, impatient services, rural settings, or inner ghettos. Nurses continue to use increasingly sophisticated technology to aid people, but remain the link between the technology and the needs of the client and family.

Thank you members of the Veterans Affairs Committee for the opportunity to bring to you our point of view. I think it is extremely important to look at the nursing shortage in a historial perspective. I am in the hopes that I was able to do so.

Luis Medina

Luis Medina RN BS

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Mortgage Bankers Association of America

STATEMENT OF THE
MORTGAGE BANKERS ASSOCIATION OF AMERICA

for submission to the

COMMITTEE ON VETERANS' AFFAIRS

of the

UNITED STATES SENATE

For the Record

on

Veterans' Administration
Legislative and Oversight Issues

S 2419, the "Veterans' Housing Amendment Act of 1988"

June 16, 1988

As requested by Senator Alan Cranston, Chairman of the Senate Veterans' Affairs Committee, the Mortgage Bankers Association of America (MBA)* submits this statement on S 2419, the "Veterans' Housing Amendments Act of 1988." The bill, which was introduced in May 1988 by Chairman Cranston at the Administration's request, provides for negotiated interest rates for Veterans Administration (VA) home loans, for modifying vendee loan sales procedures, and for repealing certain manufactured home loan requirements.

VA INTEREST RATES

Section 2 of S 2419 would change the current law on interest rates for VA loans under the home loan guaranty program. Under current law, the VA Administrator sets the maximum interest rate which veterans may pay for guaranteed loans. The proposal would allow the veteran and the lender to agree upon an interest rate for the loan so that the veteran can benefit from the best combination of interest rate and points.

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*The Mortgage Bankers Association of America is a nationwide organization devoted exclusively to the field of housing and other real estate finance. MBA's membership comprises mortgage originators and servicers, as well as investors, and a wide variety of mortgage industry-related firms. Mortgage banking firms, which make up the largest portion of the total membership, engage directly in originating, selling, and servicing real estate investment portfolios. Members of MBA include:

- Mortgage Banking Companies
- Commercial Banks
- Mutual Savings Banks
- Savings and Loan Associations
- Mortgage Insurance Companies
- Life Insurance Companies
- Mortgage Brokers
- Title Companies
- State Housing Agencies
- Investment Bankers
- Real Estate Investment Trusts

MBA headquarters is located at 1125 15th Street, N.W., Washington, D.C. 20005; telephone: (202) 861-6500.

MBA supports legislation that would free VA loans from any interest rate controls, including the regulation of either interest rates or discount points set by the VA Administrator.

Although VA has been quite responsive to market forces over the past several years in making interest rate changes, a negotiated interest rate would ensure the most efficient operation with the secondary market and minimize disruptions in the availability of mortgage credit to veterans.

While permitting a negotiated rate, the proposal would prohibit a negotiated adjustable interest rate. MBA urges that the VA be authorized to include adjustable rate mortgages (ARMs) in the home loan guaranty program. ARMs have been accepted by borrowers in the conventional mortgage market, and FHA has expanded its insurance program to include ARMs. Borrowers who do not want to pay for the predictability of a fixed rate mortgage can agree to the lower interest rates that lenders can offer when the borrower bears some of the risk of inflation and other economic conditions that generally cause rates to rise.

Whatever may have been the case previously, ARMs are no longer an untested and unknown quantity. Approximately 40 percent of new conventional mortgages originated in 1982 and 1983 were ARMs. The percentage continued to rise to 62 percent for 1984 and dropped back to 50 percent in 1985. Although substantially lower interest rates restored borrower ability to select fixed rate mortgages in 1986, ARMs accounted for 30 percent of the conventional markets.

In 1987 the demand for ARMs rose from 27 percent in the first quarter to 64 percent in the fourth quarter. ARM market share rose to 65 percent in January 1988, and as of May

1987, ARMs were the choice of 53 percent of homebuyers. (Source: Federal Home Loan Bank Board, June 1988.) Veteran borrowers should be able to enjoy this option.

VENDEE LOANS

Section 3 of S 2419 would completely remove the restrictions on vendee loan sales that become effective on October 1, 1989, including the prohibition against sales without recourse at less than par. Currently, the VA must do a cost-effectiveness comparison between selling the loans with or without recourse. In addition, the Administration's FY 1989 Budget indicates that the VA would sell vendee loans in all cases without recourse. MBA opposes that proposal. The proposal in S 2419 would allow with or without recourse sales and would require the Administrator to investigate broader financial strategies than are presently employed by the VA. Bids could only be accepted when they reflect the loans' interest rates and characteristics.

Sale of vendee loans without recourse shifts the credit risk of default from the VA to the private purchasers, who necessarily adjust their purchase prices accordingly. Because of its size, and because it is the lender, the Federal government is a more efficient manager of vendee loan credit risk than any private buyer can be. Therefore, it can be expected that the reduction in the sales price paid to the government by the private industry buyers of vendee loans will be greater than the savings the government might realize by transferring the risk of default.

MBA appreciates the efforts of the Administration to utilize professional financial advisors and to explore new marketing strategies, but would like to reiterate that it is important to note that vendee loans sold with recourse can be put into mortgage pools backing GNMA securities. If these loans are sold without recourse, it is doubtful whether they could be put in GNMA pools.

MANUFACTURED HOMES

Section 4(d) of S 2419 would change the timing, and therefore the amount, of the payment of the lender's claim on a liquidation sale of a manufactured home that secures a VA guaranteed loan. Under current law, the lender's claim is paid after the liquidation sale. The VA provides the lender with an appraisal of the manufactured home, and if the lender sells the property for that amount, the lender breaks even. If the lender sells the property for more than the appraised value, the lender's claim on the VA is reduced by the amount of the difference. If the property sells for less, the VA often grants the lender's request to reduce the appraised value.

The proposal would require the lender to submit, and the VA to pay, a claim upon receipt by the lender of the VA appraisal of the property. This would shift the risk of losses from liquidation sales to the lender. Because manufactured homes typically depreciate in value, the lender would absorb the loss in value that occurs during the interim between the appraisal and the liquidation sale.

MBA opposes this provision, which would shift the costs of the VA home loan program for manufactured homes from the VA to the lender. There is no justification for asking the lender to bear this burden.

MBA appreciates this opportunity to present its views and would be happy to provide additional information, if necessary.

National Association of Home Builders
15th and M Streets, N.W., Washington, D.C. 20005
Telex 89-2600 (202) 822-0500 (800) 368-5242

Dale Stuard
1988 President

June 23, 1988

The Honorable Alan Cranston
Chairman, Veterans Affairs Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the 155,000 members of the National Association of Home Builders (NAHB), I am submitting our statement on S.2419, the Veterans' Housing Amendments Act of 1988. I appreciate your invitation to submit written comments on this legislation, which you introduced at the request of the Administration.

Negotiated Interest Rate

The Administration's proposal to seek authority for a negotiated interest rate for VA buyers would eliminate the administratively set VA interest rate and allow for a negotiated rate between the buyer and the lender.

NAHB has voted repeatedly to support the administratively set VA rate. At our Board of Directors meeting in January of this year a negotiated interest rate was again debated and voted down. NAHB has long endorsed the VA's ability to set the program interest rate, in order to protect the interests of the veteran and the guaranty fund. We believe that the administratively set rate will give veterans a better opportunity to obtain homeownership.

Furthermore, because of its sensitivity to market conditions, the VA prevailing rate continues to be an important national benchmark for mortgage interest rates. If the VA's authority to set a maximum interest rate ceiling were eliminated, the credit markets would lose this stable measure of the cost of mortgage credit, a feature which becomes even more important in a volatile interest rate environment.

For these reasons, we continue to support the administratively set interest rate for VA buyers.

HOUSING
THE AMERICAN
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Builder Buydowns

We appreciate the Veterans Administration's explanatory language in a letter to the President of the Senate, which permits builder "buydowns". This language clarifies and reaffirms the practice by which builders and developers provide for a lower interest rate for the first few years of the loan to assist the veteran to obtain homeownership. This is consistent with present VA policy. We are disappointed, however, that recent VA policy puts more stringent requirements on obtaining a temporary interest rate buydown.

The Veterans Administration will no longer allow loans with temporary interest rate buydowns to automatically be underwritten at the lower initial payment rate. Credit underwriting will be based upon full interest charges unless there are strong indicators that the borrower's income will keep pace with monthly mortgage payment increases. Examples of strong indicators are wage increases guaranteed by labor or similar contracts. As a practical matter, most workers are not covered by these contracts and other ways should be found to demonstrate income growth adequate to keep pace with increased payments. Citing economic conditions and the fact that regular wage increases are no longer assured, the VA is disallowing underwriting at the first year's payment rate based upon routine cost-of-living increases. This policy was developed for areas of economic downturn and is not appropriate for the nation as a whole. Making long term changes in face of short term market conditions in isolated areas will not be of benefit to veterans overall.

NAHB has strived over the past several years to preserve for borrowers the underwriting advantages of buydowns and hope that the VA will continue its former flexibility in this area. This would be of particular benefit to veterans entering the homebuying market for the first time.

Adjustable Rate Mortgages

We regret that the explanatory letter, when clarifying the use of builder buydowns, states opposition to adjustable rate mortgages (ARMs). The VA had supported an ARM as a pilot program, which was dropped in conference on the 1987 VA Housing Bill. This ARM was to be patterned after the Department of Housing and Urban Development's ARM, which limits its interest rate increase to 1 percent per year with a cap of 5 percent over the life of the loan. NAHB continues to strongly support authority for the VA to guarantee ARMs. This is a very helpful mortgage instrument, since it could save a veteran about $100 a month on the average VA loan. It also enables more veterans to qualify in times of high interest rates, as well as allowing veterans a rate decrease without refinancing.

We urge the Congress to support authorization for the VA to offer this type of mortgage instrument, since the VA is the only major market participant without an ARM. As you may be aware, the new National Housing Task Force report ("A Decent Place to Live") recommends updating the VA program to include an adjustable rate mortgage. The report emphasizes that an ARM is necessary to make the program fully responsive to market developments.

NAHB would be willing to work with the VA to develop information about the performance of ARMs to address the concerns of veterans groups about the safety and soundness of an adjustable rate mortgage.

Loan Asset Sales

We are concerned with the Administration's policy decision to sell the loan assets of the VA and other federal agencies. Our concern is with the overall impact of the proposal upon the long term economic health of the various programs. In deciding which assets to sell, careful consideration must be given to assessing the true value of the income stream in determining the actual "value" of the asset sale and the long-term implications and loss to the program.

Loan assets sold without a VA guaranty (nonrecourse) present many problems. The loans being sold are by definition loans made to finance the disposition of properties acquired by the VA because a veteran went into default. By the very nature of their location, such properties make capital investors wary. Additionally, the loss of the income stream for the Loan Guaranty Revolving Fund only increases the pressure for additional appropriations.

Water and Sewage

We support the provision in the bill which repeals the requirement that denied a VA Loan Guaranty for the purchase of a new home, if the builder had a sewage system which had not been certified by local officials.

We agree with the Administration when it states that:

> "Federal, state, and local laws now adequately address the subject of individual water and sewage systems as an alternative to public and community water systems. These certification requirements place an additional burden on local officials and program participants without materially benefitting the veteran."

Thank you for allowing us to present our views.

Sincerely,

Dale Stuard

Dale Stuard
President

REALTOR®

NATIONAL ASSOCIATION OF REALTORS®

Nestor R. Weigand, Jr., President
William D. North, Executive Vice President
Stephen D. Driesler, Senior Vice President, Government Affairs
Gil Thurm, Vice President & Legislative Counsel, Government Relations
John B. Blount, Vice President, Congressional Affairs

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Telephone 202 383 1000

June 20, 1988

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
414 Russell Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the NATIONAL ASSOCIATION OF REALTORS®, I would like to thank you for this opportunity to comment, for the record of the Committee's June 16, 1988 hearings, on the proposed "Veterans' Housing Amendments Act of 1988" (S. 2419), introduced at the request of the Administration. The NATIONAL ASSOCIATION OF REALTORS® has approved policy pertaining to two provisions of the proposed bill, as follows:

Negotiated Interest Rate - The NATIONAL ASSOCIATION OF REALTORS®, as we have previously testified before the Committee, supports the provision of the proposed bill to replace the present, administratively determined VA interest rate with a negotiated interest rate. We believe that such an alteration will provide a significant benefit to veteran-homebuyers to structure loan terms favorable to their particular needs.

Sale of Vendee Loans - The NATIONAL ASSOCIATION OF REALTORS® supports the stated goal of the proposed bill to assure a maximum level of proceeds from the sale of VA vendee loans. We concur with this goal, and have opposed the Administration's sale of vendee loans without recourse, where those sales have resulted in the virtual "dumping" of VA assets. The NATIONAL ASSOCIATION OF REALTORS® supports, instead, a provision, currently under consideration by the House Committee on Veterans' Affairs' that would authorize the VA to sell vendee loans, without recourse, provided that the purchase price is at least 90 percent of the unpaid loan balance. The House proposal would also permit VA to continue to sell its vendee loans with recourse. We believe that the House proposal establishes a meaningful minimum threshold for the sale of VA vendee loans without recourse.

The NATIONAL ASSOCIATION OF REALTORS® appreciates this opportunity to comment on the "Veterans' Housing Amendments Act of 1988". Please contact me if the NATIONAL ASSOCIATION OF REALTORS® may provide any additional information.

Sincerely,

Stephen D. Driesler
Senior Vice President

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American Nurses' Association, Inc.
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Margretta M. Styles, Ed.D., R.N., F.A.A.N.
President

Judith A. Ryan, Ph.D., R.N.
Executive Director

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June 22, 1988

The Honorable Alan Cranston
Chairman
Senate Committee on Veterans' Affairs
SR-414 Russell Senate Office Building
Washington, D. C. 20510

Dear Senator Cranston:

The following are responses to the post-hearing questions submitted to the American Nurses' Association in response to our June 16th testimony before the Senate Veterans' Affairs Committee.

1. Do you believe that the VA could achieve the same kinds of success in the use of those modes as private facilities have achieved?

Yes, as we stated in our testimony we believe the VA's Nursing Service has the professional knowledge and experience to implement the research perfected by the nursing profession. ANA also believes that the Nursing Service has the specific knowledge as to what modes of nursing practice are appropriate for the VA.

2. Wouldn't you agree that section 9(b) (1) (D) of S. 2462 leaves to the VA the selection of nursing practice modes under the pilot program?

We believe that section 9(b) (1) (D) of S. 2462 gives the VA authority to implement alternatives for using the professional skills and knowledge of registered nurses in direct patient care services. However, we believe that the designation of the pilot programs as listed in section 9(b) (1) (A) and (B) may lead the VA to believe it only need to implement congressionally designated nursing pilot programs. As the Chairman has pointed out the VA has failed to authorize previously requested nursing programs. We believe the VA Nursing Service should have the flexibility to choose and request appropriate nursing demonstration projects.

Historically, when there has been administrative support this has been the case; the VA Nursing Service has been in the forefront of innovative delivery systems such as nurse administered clinics and units, nursing home units and various other initiatives. ANA understands that the Committee's intention

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is to make the VA responsive to its Nursing Service's needs. It is unfortunate that in the last few years the Committee has had to repeatedly admonish the agency regarding its failure to exercise programs and budget authorities to address nursing recruitment and retention. ANA suggests that S. 2462 clarify that Nursing Service should receive the VA's administrative support, appropriate approvals and monies to carry out nursing practice and research.

3. Please identify the facilities involved and provide any information you may have regarding the results of these programs.

ANA understands that collaborative practice committees are in existence at several VA medical centers. Primary nursing and its variations are being utilized in several facilities as well. In addition, other innovative practice modes are being tried at various facilities. The VA in its testimony, page 13, also indicated its recent or pending approval of pilot programs. Although, we do not have the results of such existing programs, the VA should be able to provide the pertinent information regarding its experiences.

If we can be of further assistance, please feel free to contact me. We look forward to working with you on Veterans health issues as well as many more.

Sincerely,

Gloria

Gloria S. Hope, Ph.D., R.N.
Director
Division of Governmental Affairs

(Washington Office)

GSH:mm

We appreciate your sustained support of the VA nursing service.
Thanks. Gloria

American Psychological Association
Advancing psychology as a science, a profession, and as a means of promoting human welfare

July 8, 1988

Ms. Barbara Masters
Committee on Veterans' Affairs
United States Senate
SR-414 Russell Senate Office Building
Washington, D.C. 20510

Dear Barbara:

Enclosed please find the answers to questions that the Committee requested in connection with the June 16 hearing. Dr. Boudewyns recently forwarded his responses to me.

We very much appreciate your hard work on the hearing, and thank you for your patience with our internal confusion. If I can be of any further assistance, please let me know.

Sincerely,

Sheri S. McMurray

Sheri S. McMurray
Associate Lobbyist

Enclosure

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RESPONSES TO THE FOLLOW-UP QUESTIONS SUBMITTED BY SENATOR CRANSTON TO THE AMERICAN PSYCHOLOGICAL ASSOCIATION IN CONNECTION WITH THE VETERANS' AFFAIRS COMMITTEE HEARING OF JUNE 16, 1988

Question 1: From the perspective of your organization and your university experiences, what factors are the most important in recruiting high quality psychiatrists and psychologists to a hospital or medical center and how important, in order to recruit and retain good clinicians, is it to provide access to and opportunities for a top-notch research program?

APA's Response: To answer this question it will be necessary to provide some background information. It has always been difficult to recruit physicians of any kind, but especially psychiatrists, to work in the VAs. The pay is relatively low and the type of patients in the VAs are not always the most cooperative. Traditionally, therefore the psychiatrists and the psychologists who have worked in the VA have not always been of the highest quality. This situation has improved considerably over the years as a result of the VA Medical Center effort to develop associations with top quality medical schools. Typically, these "Deans' Hospitals" as they are called have been able to attract better quality psychologists and psychiatrists because they offer more opportunity to do research and training. Those hospitals that do not have the close association with medical schools are typically unable to recruit well in either discipline. In recent years the situation has gotten a little better for psychology and worse for psychiatry. This is because there has been a steady decrease in the number of physicians who choose psychiatry as a speciality over the past ten years, while there has been a steady increase in the number of clinical psychologists. The two trends are probably not unrelated. Those students in undergraduate school who are interested in human behavior and abnormal behavior now often choose to go directly to graduate schools of clinical psychology and bypass what they see as irrelevant medical school training. This has become especially true in recent years as the profession of clinical psychology gains in terms of both public recognition and financial reward. Further, I have noted that as clinical psychologists gain the advantage of third party payment, more young clinical psychologists are going into private practice. This trend is now beginning to affect recruitment of psychologists in the VA. We expect that if this trend continues that within the next three to four years there will also be a severe recruitment problem for VA psychology positions similar to the situation in the 1960's when the VA could not recruit clinical psychologists simply because there where just not enough trained and because the pay was too low. Thus, it is expected that recruitment of mental health professionals to work in the VA will be a continuing problem.

This will include psychologists, psychiatrists, social workers, and nurses, as well as other ancillary specialities. Having opportunities for top-notch research programs is one way to help resolve this problem especially for psychology and psychiatry.

Question 2: What do you think are the benefits of creating centers of excellence, like the MIRECCs, as compared to simply funding more mental illness research?

APA's Response: The MIRECCs would create an environment conducive to the development of multidisciplinary research efforts--similar to the very productive Geriatric Research Education and Clinical Centers, or GRECCs, established by the VA in the early 1970's. The MIRECC concept proposes multidisciplinary centers that will allow several mental health disciplines, including psychologists, psychiatrists, and other physicians, social workers, nurses, and other mental health specialists to interface in their research training for patient care efforts. The multidisciplinary approach is of particular importance to the various mental health professions that must access and treat an array of interactive emotional, physical, cognitive, and interpersonal problems that mentally ill patients present.

The present system of VA research funding is primarily concerned with providing resources to a single researcher to address his or her circumscribed area of interest, on a short term basis. While most areas of physical medicine can be effectively investigated in this manner, many areas in mental health and illnesses, such as psychological treatment outcome research for example, require intensive multidisciplinary efforts with long term follow-up that can be more effectively addressed by cooperative studies designed in centers such as those proposed by this legislation.

Question 3: What particular areas of mental illness research should be given priority at the MIRECCs -- biomedical, psychosocial, or health service?

APA's Response: Again, no one area should be emphasized in MIRECCs. Mental health research is by nature a multidisciplinary approach that cuts across and involves the understanding of the interaction between the biomedical, psychological, social, and cultural levels of human experiences. The goal of the MIRECCs, as indicated in my response to question number two, should be to promote the interaction of these levels.

Question 4: Please note any specific areas, such as PTSD, substance abuse, and schizophrenia, on which you think it is especially important for the MIRECCs to focus.

APA's Response: This is difficult to answer. There are so many unanswered questions in mental illness that it would be presumptuous to say that we should emphasize one or the other. However, some areas of mental illness have been researched more than others. For example there is already a center in the VA for the study of schizophrenia. Because the VA has an abundance of schizophrenics to study, this is an area that needs continued emphasis. However, if any one area is to be emphasized perhaps PTSD would be the most likely candidate. PTSD is a unique problem for the VA because so many Vietnam Veterans suffer from this disorder. It was not until recently that we have seen how devastating this disorder is for veterans who are exposed to the horrors of combat in Vietnam at a very early age. Further, compared to schizophrenia or bipolar affective disorder the VA has spent less to understand PTSD. Finally, one could argue that PTSD could be the only psychological-psychiatric disorder that is in the most basic sense "service connected" or directly related to military service.

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JUN 21 REC'D

June 16, 1988

Jonathan R. Steinberg
Chief Counsel
Staff Director, Committee on Veterans Affairs
Senator Alan Cranston's Office
United States Senate
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Dear Mr. Steinberg:

I would like to thank you for your constructive comments during the public hearing this morning for the Committee on Veterans Affairs. The hearing was well organized and I am particularly grateful to Ms. Barbara Masters for making the arrangements.

I am responding at this time to the follow-up questions submitted to me after my testimony. The first question dealt with the factors in recruiting high quality psychiatrists and psychologists. The important factors include all aspects of working conditions. This encompasses the quality and quantity of support staff, the presence of an interesting patient population, the opportunities for teaching and the opportunities for research. When I recruit a new psychiatrist or psychologist, I come to an agreement in advance with the individual as to what his or her service responsibilities are and how much time will be available for teaching and research. The presence of interesting colleagues and the opportunity to exchange ideas with colleagues are other important assets. Generally we have succeeded in recruiting our best clinicians because of their interest in doing research with a particular colleague on a particular project.

Question 2 - the value of MIRECCs compared to simply funding more mental illness research. This is not an either or situation. We should fund the MIRECCs because the Research Center idea has worked for NIH, NIDA, NIAAA and for NIMH. Centers stimulate research by putting together a critical mass of investigators. These investigators are then free to apply for funds through the regular grant review process both within the VA and from outside of the VA. These people also eventually leave the Research Center and go elsewhere, hopefully within the VA. Because of their experiences within the MIRECC and because of the stimulus produced by putting together a critical mass of top-notch investigators it is likely that there will be more good applications for mental illness research through the regular Merit Review process. Our problem right now is that we do not have enough good mental health applications to compete successfully for the research dollar. I would anticipate that the MIRECCs would increase the proportion of mental illness research in the Merit Review process by improving the overall quality of applications in the mental health area.

Question 3 - regarding the areas of mental illness research which should be given priority at the MIRECCs. It is my recommendation that we make the concept as broad as possible. I would not specify biomedical, psychosocial or health services but would rather let the announcement read that all of these types of research would be competitive. Then I would make sure that the review committees are balanced across these areas and let the best projects win. I think that always we should go for the highest possible quality and not fund lower quality applications in a particular area such as health services, for example, just because we think that we would like to have applications in that area.

Question 4 - Specific areas such as PTSD, substance abuse and schizophrenia are especially important for the MIRECCs to focus. In my opinion the announcement should include that the MIRECCs should be relevant to the mission of the VA. And since they would be studying VA patients it is likely that they would include diagnostic areas which are important to the VA. These include substance abuse, schizophrenia, Alzheimer's Disease, affective disorders, PTSD and others. Using the policy expressed in my answer to question 3, I would let the quality of the proposals dictate the areas. I also think that it is likely that each MIRECC would include investigators doing studies across several different diagnostic areas. In other words, it would not be necessary that a given MIRREC focus only on schizophrenia or only on substance abuse. The critical factor would be that it would be research relevant to the mission of the VA, but this could be broadly interpreted by the review committee.

I hope that these answers will be useful for you. As I said at the hearing, S.2463 is a good proposal. It will not solve all of our problems, but it is clearly an innovative and effective way to start. I anticipate that this program, if enacted, will set in motion a chain of events which will continue to have positive ramifications on the VA for many years to come.

Yours sincerely,

Charles P O'Brien

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The American Legion

For God and Country

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June 30, 1988

Senator Alan Cranston
Chairman
Committee on Veterans Affairs
U.S. Senate
Washington, DC

Dear Senator Cranston:

This is in response to your follow-up questions to the hearing of June 16, 1988, with respect to S. 2511, S. 2294, and S. 2462.

Concerning the proposal of S. 2511 to provide assistive monkeys and signal dogs to certain disabled veterans, at the June 16th hearing we expressed our support for the concept of the proposals of S. 2207 and S. 2511 to provide, either by statute or under a pilot program, assistive monkeys and dogs to quadriplegic veterans as well as a pilot program to provide signal dogs to deaf veterans. These proposals represent innovative approaches to providing certain types of care and assistance to severely disabled veterans. We do, however believe the VA should be afforded the opportunity to fully evaluate the benefits and problems for the recipients of assistive animals and the overall cost-effectiveness through the pilot programs as proposed by S. 2511.

With respect to S. 2294, section 2 of this bill would extend the VA's authority to contract for drug and alcohol treatment in half-way houses and other community-based facilities. The American Legion is supportive of this proposed extension.

The VA needs to continue providing non-institutional care for veterans suffering from alcohol and drug abuse. Hospitalization for alcohol and drug abuse is just the beginning phase of treatment. Since substance abuse treatment is an ongoing process, contractual arrangements with halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities are essential in order for the initial treatment to be effective. The transitional care which non-institutional treatment facilities provide is cost-effective and oftentimes enables veterans to secure employment in the after-care component of their treatment and, thus, greatly contributes to developing stronger self-esteem and greatly enhances the path to recovery.

Since the time of the last extension of VA's authority to enter into contractual arrangements with community-based substance abuse treatment facilities, Diagnostic Related Groupings (DRGs) have significantly reduced the average length-of-hospital stay. Because of the impact of the DRGs, it is more vital today that community-based treatment facilities are made available. The medical model today for substance abuse treatment encourages a short hospital stay, with a strong after care component. Certainly, the number of such community-based treatment facilities should be expanded based on the DRGs impact and additional funding must be made available to accomplish this worthwhile treatment model.

At the end of FY 1987, three hundred and fifty eight contracts at 94 medical centers were in effect. Over the past several fiscal years, approximately 5,000 veterans per year have been outplaced into non-VA contract programs for 60-90 days of care, utilizing VA financial resources. Through visits to VA medical centers by our National Field Representatives, it is apparent that the VA is straining to stay within the authorized FY 1988 budget level of $5.4 million for non-VA contract programs, and in order to continue meeting the demand for community-based substance abuse treatment, the amount of funding required for this effort must be increased.

Prior to the implementation of the DRGs, the average length-of-stay for inpatient alcohol treatment averaged 30 days and drug treatment was generally provided within a therapeutic community program often averaging a six to nine month hospital stay. Today, both alcohol and drug treatment are assigned an inpatient length-of-stay of 16.5 and 17.5 days, respectively.

Because of the reduction of length-of-stay in the alcohol and drug treatment programs, it is essential that the VA be authorized to extend and expand non-VA contract programs and to provide the accompanying resources.

Section 3 proposes an extension of the VA's authority to provide respite care services through September 30, 1991. On June 16, 1988, The American Legion testified in support of S. 2446 which would extend provision of this type of care through September 30, 1990. However, in view of the substantial delay in issuance of guidelines and instructions to the medical centers and the actual startup of this program, we believe additional time is necessary to more fully develop and evaluate the benefits and cost-effectiveness of such care and we would favor a two year rather than only a one year extension of this program.

Section 4 would authorize the VA to pay the emergency medical services for certain veterans participating in the vocational rehabilitation program under Chapter 31, when the veteran cannot reasonably obtain emergency medical care through the VA or other government facilities. The current provision for medical services for Chapter 31 participants contained in 38 USC 628(a)(2)(D) does not apply to those individuals in the program of independent living services nor to those who may have completed the training phase of their vocational rehabilitation but were not yet employed. The proposed amendment would clarify that all Chapter 31 participants would be authorized emergency medical care, as specified. The American Legion supports this proposal.

Section 5 would extend the VA's authority to make grants of up to $500,000 annually to the Veterans Memorial Medical Center in the Philippines through 1994. The VA's current authority for such grants expires in 1989. Under the extension, as proposed, funding would be available for the training and education of health service personnel at the Veterans Memorial Medical Center and replacement and upgrading of certain facilities and equipment. The delegates to The American Legion 1986 National

Convention adopted Resolution No. 29 in support of the U.S. Government's continuing financial support to the Veterans Memorial Medical Center for the medical and nursing care of Philippine Commonwealth Army veterans and New Philippine Scouts.

Section 6 proposes an increase in the per diem rates the VA pays to States for the care of veterans in State veterans' homes. The rate for domiciliary care would be increased to $10.67 and a single rate of $20.48 would be payable for both hospital and nursing care. These rates were adjusted to $8.70 and $20.35 respectively, in April 1988 pursuant to PL 100-322. We note the provision of PL 100-322 adjusting the per diem rates is applicable to payments made for 1987. In addition, this legislation also authorized an annual review and revision of the rates of reimbursement by the VA, effective October 1, 1988. The American Legion supported the enactment of this legislation to ensure an appropriate level of continuing support to the program of cost-sharing with the States for the care of veterans. On this basis, we will support the proposed increases.

Section 7 would amend sections 4142 and 4143 of the title to provide the VA with needed flexibility in authorizing scholarships for health-care professionals and would define and clarify the period of obligated VA service for those receiving such scholarships. We are not opposed to this proposal.

Section 8 would authorize the VA to reimburse nurses for tuition expenses incurred for professional courses leading to a nursing degree. We strongly support this proposal, as it would help in the overall effort to ease the critical nursing shortage that exists in the VA.

Section 9 would extend through FY 1992 the program of grants to States for the construction, acquisition, remodeling or expansion of State veterans home facilities.

The American Legion has long been a staunch supporter of the Federal Government's efforts to assist the States in providing care for veterans and we strongly endorse the proposed extension of the VA's authority to make grants for this purpose.

Section 10 would extend the date by which the VA must report to Congress on its evaluation of the respite care program to September 30, 1991. The respite care program was established by PL 99-576. We expressed our support of the extension of the program's operation as proposed by Section 3 of this bill and also believe that additional time is necessary for the VA to study and analyze the program over an extended period of time before it reports to Congress.

Section 11 would make the per diem rates for care in State veterans homes proposed in section 6 of this bill effective October 1, 1988. We support this provision.

With respect to your third question concerning the proposal contained in section 7 of S. 2462, this measure would modify the requirement that the VA recover the full cost of services provided to other health-care facilities, entered into through sharing agreements, by providing greater flexibility to the managers of the facilities concerned in setting rates and thus facilitating fuller use of resources. The American Legion encourages the development of a strong relationship between the VA and community health services. We believe the VA can provide optimum service to other health-care facilities at competitive costs, if the current legal constraint of 5053(b) of the title were removed or substantially modified. We would also have no objection to the delegation of the authority to set the rates of reimbursement to the director of an individual VA medical facility.

We appreciate the opportunity to offer these additional comments.

Sincerely,

E Philip Riggin

E. PHILIP RIGGIN
Director
National Legislative Commission

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO DR. TSUANG AND DR. MAGRAW AND THE RESPONSES

1. The most important factors in recruiting high quality psychiatrists and psychologists are as follows:

a. Clinical work should be carried out in an academic environment with adequate research and educational opportunities. The specifics of these are listed below.

1) Responsibility for clinical work on direct patient care must be maintained at a reasonable level. This means the number of staff psychiatrists in most institutions must be substantially increased.

2) Consistent opportunities for study and research are understood as an essential part of professional work.

3) Opportunities (this means primarily time) for writing grants and papers must be provided.

4) Participation in teaching students and learning through seminars, etc., are understood to be a regular part of professional work.

b. Pay commensurate with remuneration in like work elsewhere is essential.

c. Reasonable working conditions should be present. This includes administrative support (including secretarial) which is adequate, and a limitation on non-professional demands made on the clinician.

2. Access to and opportunities for top notch research programs in recruitment and retention of psychiatrists in the VA is extremely important. In the instance of the Minneapolis VAMC, we recently lost three excellent young psychiatrists at one time to a single academic institution, almost entirely because the discrepancy between research opportunities there and what is possible here.

3. Creating centers of excellence like the MIRECCs provides the following benefits:

a. A stable mode of funding which promotes a strong clinical academic focus which can be maintained despite variations in level of other grant funding.

b. The provision for some geographical dispersal of regional centers of excellence brings the leavening effects of academic programs into various sections of the country, rather than having them limited to two or three a reas.

c. Another benefit is that a specific process for disseminating information and resources for carrying it out are included in the Center concept and in the funding.

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4. The order for mental health research priorities should be as follows:
   - -- biomedical
   - -- psychosocial
   - -- health services

5. The areas of special concern or focus, listed in order of priority, would be as follows:
   - -- schizophrenia
   - -- affective disorders
   - -- the aging mentally ill
   - -- substance abuse.
   - -- post-traumatic stress disorder

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WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

QUESTION 1.

On page 2 of Dr. Wyant's testimony, he states that during FY 1988, 68 percent of veterans completing an initial evaluation were found eligible and entitled to rehabilitation services and assistance under chapter 31. Please provide the percentages found eligible for each of fiscal years since 1980 through 1987.

RESPONSE: We do not have valid data for the period prior to fiscal year 1984. Below are the percentages found eligible for fiscal years 1984 through 1988.

1984	63%
1985	70%
1986	73%
1987	69%
1988	68%

QUESTION 2.

On page 3 of Dr. Wyant's testimony, he indicates that one-third of the 24,175 veterans participating in a chapter 31 program of rehabilitation services have serious employment handicaps.

A. What percentages of the 24,175 veterans have 10-percent ratings and 20-percent ratings?

B. What percentages of the veterans with 10- and 20-percent ratings have serious employment handicaps?

RESPONSE: Of the 24,175 veterans, 25% have 10-percent ratings and 17% have 20-percent ratings. At this time we are unable to answer part B in that the data is not immediately available. A computer search will be necessary to gather the data and will be accomplished as soon as possible. We will respond to your inquiry within approximately 15 workdays.

QUESTION 2B.

What percentages of the veterans with 10- and 20-percent ratings have serious employment handicaps?

RESPONSE: 5.9 percent of veterans with 10 and 20 percent ratings have serious employment handicaps.

QUESTION 3.

On page 6 of Dr. Wyant's testimony, he states that the VA has initiated action to revise and update the VA-DOL employment services agreement.

A. When was this revising and updating process initiated?

B. When was the agreement last revised?

C. When will the agreement be completed?

D. What use is proposed for DVOPs in connection with the chapter 31 program under this agreement?

E. Please provide copies of all communications between VA and DOL on the development of this agreement.

RESPONSE: A. May 26, 1988.

B. June 26, 1984.

C. We anticipate completion of the agreement in August, 1988.

D. While no firm percentage has as yet been agreed to between VA and DOL, greater usage of DVOPS at Vocational Rehabilitation offices is anticipated and will be incorporated into the agreement. The DVOPS will be used to assist Vocational Rehabilitation graduates secure meaningful employment.

E. All communication on the development of this agreement has taken place either on the phone or in personal meetings between the VA and DOL representatives.

QUESTION 4.

Page 13 of the written testimony of the Veterans of Foreign Wars states that, to the knowledge of the VFW, no DVOPs are currently being used in the furnishing of employment assistance to a veteran with a service-connected disability who has participated in a vocational rehabilitation program under chapter 31 or a similar program under the Rehabilitation Act of 1973 and who the Administrator has determined to be employable.

A. Is the VFW's impression accurate?

B. Do you have any plans to make use of DVOPs for this purpose?

RESPONSE: There are 66 DVOPs who spend some or all of their work-time in 38 VA Vocational Rehabilitation and Counseling divisions. Nearly 3,000 person-hours per month are spent by DVOPs in VR&C, and nearly 9,000 person-hours are spent by them each month at all VA facilities. Many of these DVOPs accomplish much in job placement and job development activities and are seen as a valuable resource in the rehabilitation process.

QUESTION 5.

Page 13 of the VFW testimony and page 8 of the Disabled American Veterans testimony state that members of the Armed Forces who are placed on the temporary disability retired list are not notified of their eligibility for vocational rehabilitation unless these individuals file for VA benefits.

A. Is this correct? If so, what corrective action do you plan in order to provide such information to discharged veterans?

B. The VFW states that these individuals should be informed about their eligibility and that this could best be accomplished by the Physical Examination Board Liaison Officer (PEBLO). What is your view of this recommendation?

RESPONSE: A. This is incorrect. Members of the Armed Forces who are placed on the temporary disability retired list are issued Form DD214, as are all members released from active duty. Under the Veterans Administration Discharge System (VADS) a copy of each DD214 is sent to the VA Data Processing Center in Austin, Texas. The information is entered in the computer system which generates a letter to the veteran informing him or her of the VA vocational rehabilitation program as well as other VA benefits, and the nearest VA Regional Office.

B. We are working with the Department of Defense to encourage a policy of informing military personnel awaiting release from active duty of the VA vocational Rehabilitation program. Because the PEB liaison is a DoD employee, we would defer to their judgment as to whether this is the best method to accomplish this goal.

QUESTION 6.

Page 14 of the VFW testimony states that information about the VA's Vocational Rehabilitation Program is not being provided to disabled veterans who are discharged from military hospitals or "administrative holding companies". Is this correct? If so, what corrective actions do you plan in order to provide such information to discharged veterans?

RESPONSE: This is incorrect. Every veteran discharged from active duty is contacted by the VA through the VADS procedure referenced in our response to question #5 above.

QUESTION 7.

Page 5 of the DAV testimony recommends that in-depth training, similar to that currently being provided to DVOPs and LVERs at the National Veterans' Employment and Training Services Institute, needs to be implemented for the Vocational Rehabilitation and Counseling (VR&C) staff.

A. What is the feasibility of an agreement with the DOL under which the VA could purchase or otherwise obtain training services for VR&C staff through the NVETSI.

B. If such an approach is feasible, do you plan to arrange for such training?

RESPONSE: With the enactment of S.999, the Veterans' Employment, Training and Counseling Amendments of 1988 (Pub. L. No. 100-323), the Secretary of Labor has been authorized to provide training to certain Department of Labor staff at the National Veterans' Employment and Training Services Institute (NVETSI). Additionally, other personnel involved in the provision of employment, job training, counseling, placement, or related services to veterans may be provided the training services through NVETSI.

We have had discussions with staff of the Assistant Secretary for Veterans Employment and Training and believe, given sufficient funding, DOL will allocate a number of training slots to VR&C staff, beginning in FY 1989. Travel expenses, training costs, and per diem will be from DOL appropriations.

QUESTION 8.

Page 9 of the DAV testimony states that two individuals who have been assigned to review chapter 31 vocational rehabilitation cases to determine if Congressional mandates are being carried out have had their positions downgraded.

A. Is this correct?

B. If so, why were the positions downgraded and what are the former and current grades of these individuals?

RESPONSE: In 1984, the Committee for Employer Support of Veterans Employment (CESVE) was established to promote the employment of veterans in the private sector. The VA appointed two staff members, one at the GM-15 level and the other at GM-14, to coordinate the activities of the Committee. The Committee's activity had some positive results and a large number of employers made commitments to give preferential consideration to the employment of veterans. When this goal was achieved, the two staff members were reassigned to the Department of Veterans Benefits' Vocational Rehabilitation and Education Service to work on policy issues involving the employment of veterans, and particularly disabled veterans, in the public and private sector. Because of their experience, one part of their new position's responsibilities involved the review of chapter 31 cases in which veterans were rehabilitated. After one year of employment in the VR&E Service, a position classification review was conducted and it was determined that the duties and responsibilities of the two positions would be most appropriately graded at GM-13. The positions were so graded, but, under OPM rules, the incumbents will retain their former grades for a period of two years and salaries indefinitely. We view the addition of these two people as a significant improvement in our emphasis to improve employment assistance and job opportunities to veterans.

QUESTION 9.

On page 9 of its testimony, the PVA recommends that "[e]ach Regional Office/VAMC rehabilitation program must have a leader, such as a VR&E Counseling Psychologist, with the authority to prioritize the efforts of his vocational rehabilitation team consisting of personnel from both departments." What is your view of this recommendation and its feasibility?

RESPONSE: The VA already has in place a system which essentially meets the concerns of PVA that "each Regional Office/VAMC rehabilitation program must have a leader, such as a VR&E Counseling Psychologist, with the authority to prioritize the efforts of his vocational rehabilitation team consisting of personnel from both departments." The Department of Veterans Benefits (DVB) and the Department of Medicine and Surgery (DM&S) have a coordinated case management system which integrates the VA's multifaceted rehabilitation services. There are actually two leaders, one in DVB and one in DM&S, who use their specialized knowledge of their respective departments to coordinate the delivery of services under a detailed division of labor. This system assures delivery of needed services to veterans by the department which can best provide the services.

The DM&S case manager takes responsibility for veterans who are being provided rehabilitation services solely by DM&S. This includes veterans with either service- or nonservice-connected disabilities who are hospitalized. Service-connected veterans are provided case management assistance on a priority basis. Upon discharge from a DM&S facility of a veteran who is eligible for chapter 31 vocational rehabilitation, the DM&S case manager coordinates and facilitates the transfer of case management responsibilities to the DVB case manager. The DM&S case manager also assists the DVB case manager to assure timely and appropriate delivery of DM&S services to chapter 31 program participants so these veterans can continue to progress toward their rehabilitation goals.

For participants in chapter 31 who are not hospitalized in a DM&S facility, the DVB case manager in the Vocational Rehabilitation and Counseling (VR&C) Division of the regional office has the responsibility for coordinating and directly monitoring a veteran's vocational rehabilitation program. This monitoring is accomplished through personal contact with the veteran and with facilities and agencies providing services which are established in the veteran's rehabilitation plan.

If a DM&S facility provides services as part of a chapter 31 vocational rehabilitation program, the VR&C Division case manager has the responsibility to coordinate with the DM&S case manager concerning these services. Initially, the VR&C case manager will contact the DM&S case manager to ensure that the DM&S facility can and will provide the needed services. Later, the VR&C case manager will monitor jointly with the DM&S case manager the actual delivery of DM&S services.

QUESTION 10.

On page 22 of its testimony, PVA urges the Veterans' Affairs Committee to obtain meaningful statistics from the VA in order to determine if there are veterans who would be "feasible for training" yet are unable to participate because of a limit on the number of pensioners that can be evaluated -- which is 3,500. Do you have data on the number of veterans for whom job training would be feasible but who cannot participate in the program due to the 3,500-evaluations limitation? If so, please provide such data.

RESPONSE: We do not believe there are any VA pensioners who have been unable to participate in an evaluation because of the limit on the number of evaluations which can be provided during a program year. When the program of vocational training for certain pensioners was first enacted in 1984, there was a limit of 2500 on the number of veterans who could be provided an evaluation. We recognized that there was a very real possibility that the number of veterans for whom an evaluation was required could exceed the then 2500 limitation on the number of evaluations which could be furnished during any 12 month period. Our instructions provide that if a veteran cannot be provided an evaluation during the 12 month period because of the limitation on the number of evaluations, the veteran will be given priority for evaluation during the following 12 month period.

Program experience indicates we have not had to use the procedures described above. The number of veterans provided evaluations during the first program year was well below the 2500 limit. Since that time the number of evaluations has grown rapidly. When it appeared that we would have to curtail provision of evaluations during the the current program year, Congress increased the number of evaluations which could be furnished in Public-Law 100-227, the Veterans' Compensation Cost of Living Adjustment Act, enacted December 31, 1987, to 3,500. We believe that this limit would not operate to deny an evaluation to any pensioner.

QUESTION 11.

On page 4 of Dr. Wyant's testimony, he states that the VA has expanded its use of contracting for certain extended evaluation services with non-profit organizations.

A. How many veterans received extended evaluation services through these contractual services in 1987 and what was the dollar value for these contracts?

B. How many veterans in FY 1987 were provided extended evaluations by your own personnel?

C. What are your projections for fiscal years 88 and 89 with respect to veterans who will receive extended evaluation services through such contracts, and the dollar value of the contracts, and the number who will receive extended evaluations directly by VA staff?

RESPONSE: The data was not immediately available and we are unable to respond to this item. We have taken steps to collect the data and will provide the requested information as soon as possible. We should be able to supply a response in 15 workdays.

RESPONSE: This response was not included in our earlier submission as additional information from field stations was needed. The data has now been collected and the response follows:

A. The number of disabled veterans provided extended evaluation by contract with cost to the VA was 689. The dollar value for these contracts was $981,802.91.

B. VR&C field staff was involved in the evaluation, planning, and supervision of the veterans served in the 689 contracts mentioned in item A above. In addition, 95 agreements for extended evaluations were completed with staff of the Veterans Administration's Department of Medicine and Surgery. An additional 110 extended evaluations were initiated by agreement with other agencies at no cost to the Veterans Administration.

C. It is projected that for FY 88, some 720 disabled veterans will be provided extended evaluations by contract with cost to the Veterans Administration. The value is expected to be about one million dollars. A further increase is expected for FY 89 with the contract value reaching nearly $1,055,000.00. Again, VR&C staff will be involved in the planning for extended evaluation programs and will be maintaining contact with disabled veterans receiving these services. Staff of VA's Department of Medicine and Surgery, through agreements with VR&C Divisions are expected to provide extended evaluation programs for just over 100 disabled veterans in both FY 88 and FY 89.

QUESTION 12.

A. In light of the increase in average vocational rehabilitation specialist caseloads -- which adversely affects the timeliness of all chapter 31 services -- did the VA ask OMB for an increase in FTEE for FY 87? If so, in what amount?

B. Did the VA request an FTEE increase for FY '88? For FY 1989? If so, in what amount(s)?

RESPONSE: The budget submission to OMB for 1987 requested an increase of 11 FTEE. The submission for 1988 included an increase of 5 FTEE. The 1989 VA budget submission included a decrease of 5 FTEE which was in part the result of reassigning the cost of Central Office VR&E staff from the CP&E program to the VR&E program.

QUESTION 13.

A. With respect to the use of contract counseling services for participants in VA education, vocational training, and rehabilitation programs, which types of services do you consider it most important and appropriate to obtain through contracts and for which categories of veterans do you consider it most important and appropriate to obtain services through contracts? Please give your reasons.

B. Are there any particular types of services which, or any categories of veterans which, you would consider contract counseling inappropriate? If so, please give your reasons.

RESPONSE: A. The following categories of contract services are considered most important to conserve resources and provide comprehensive services to eligible veterans under various education and vocational rehabilitation programs:

a. Contract Counseling Services: These contracts, when used to provide educational and vocational counseling services to entitled veterans in programs other than chapters 31 and 15, can insure timely and quality services without detracting from the services to disabled veterans who apply for services under chapters 15 and 31.

b. Rehabilitation Programs. These contracts include services to seriously disabled veterans for:

(1) Extended evaluation in specialized rehabilitation facilities as a means of establishing the individual's feasibility for vocational rehabilitation services.

(2) Independent Living Services. These contracts are essential to conduct programs of independent living, especially with regard to services or geographical areas where DM&S facilities cannot provide services.

(3) Homebound. Homebound programs for seriously disabled veterans require contracts for services to include training and other services.

(4) Self Employment Programs. Veterans for whom self employment is planned require extensive assistance that can best be provided through contract with individuals or secured through agreement with the SBA to assist the veterans in studying the feasibility of self employment and the development of a plan.

(5) Employment Services. For those veterans who are seriously handicapped and experience difficulty in securing employment, contract employment services are used to assist the veteran in marketing himself or herself and to provide individual assistance until successful placement is achieved. Additionally, contracts for job site modification to accommodate the physically limited would be appropriate under this category.

(6) Ancillary Services. Contracts are used to provide tutorial services, reader service, and transportation services for seriously physically impaired.

B. We would consider contract services to be inappropriate for those counseling services involving decisions concerning entitlement and types of program services needed. These activities should remain the responsibility of DVB Vocational Rehabilitation and Counseling staff in order that accountability be maintained.

QUESTION 14.

Section 1517(a)(2)(d) of title 38 provides that assistance under section 1517(a) (assistance for certain service-disabled veterans in obtaining employment) may include "utilization of job development and placement services of . . . (iv) . . . public or nonprofit organizations having placement services available." If this authority were expanded to include the services of private, for-profit entities, would you consider it useful and appropriate to acquire their services? Please give your reasons and, if your answer is in the affirmative, provide specific examples of the circumstances and geographical areas in which you might wish to make use of the expanded authority.

RESPONSE: We are currently studying whether it would be useful to expand the authority to provide job development and placement services to some private or for-profit service providers. VR&C staff provide employment assistance through assessment of the veterans' needs in this area i.e., resume preparation, interview skills, job hunting strategies, etc., and, with assistance of DVOPs, state department of vocational rehabilitation staff, and placement staff of colleges and universities, directly provide the required services. However, we have noted that some veterans require more extensive services and followup for specific job development and direct placement. This requires a great deal of labor intensive activity by a person trained in this area and this is rarely available through a public or not-for-profit service provider.

QUESTION 15: Mr. Morani, page 2 of the March 21, 1988, I.G. audit of the VA vocational rehabilitation program states that the audit work included a "review of 130 veterans' records randomly selected via statistical sampling techniques to determine whether veterans enrolled in the program met established eligibility criteria and were placed in training consistent with their abilities, aptitudes and interests."

A. To what universe of veterans are you attempting to generalize the findings from the survey of 130 records, how many veterans are in these univereses, and what percentage of the universe of veterans to which you are generalizing findings does the sample represent?

B. What is the confidence interval and level/degree of precision associated with the sampling of 130 folders?

RESPONSE: As stated in page 2 of our audit report, we selected two separate samples from an overall universe of 27,000 veterans who participated annually in the VA Vocational Rehabilitation Program. Specifically, the 130 records for one of the samples were randomly selected from a universe of 14,164 veterans who were approved for training during the year ended February 1986. Our sample represented about one percent of the universe of veterans in that category. The results were then used to estimate an annual impact on program costs. Based on actual results in this sample, the audit achieved a 90 percent confidence level and a precision level of plus or minus 7 percent.

Question: 16A. Does the Department of Medicine and Surgery's Resource Allocation Methodology (RAM) in any way recognize a priority for, or attach particular value to, the furnishing of care for service-connected disabilities or care for the disabilities of chapter 31 participants or any other service-connected disabled veterans?

Answer: The Department of Medicine and Surgery's Resource Allocation Methodology (RAM) is neutral with respect to priorities for care. The RAM weighted work unit value for a specific modality of treatment will in all cases be the same determination, without regard to the veteran's priority for care.

Question: 16B(i). (If so) Please describe in detail the specific aspects of the RAM which do so.

16B(ii). (If not) Please describe how you ensure that in the furnishing of health-care services appropriate priority is afforded these veterans.

Answer: Priorities for care are promulgated as Department and Agency policy. It is rare that a question is raised concerning appropriate implementation of the priorities. When such a question has been presented, action is taken to insure correct implementation.

QUESTION 17: Page 9 of the DAV's testimony states that the VA's proposal, in section 6 of S. 2149, to offset federal tax refunds to collect VA home loan debts is "a procedure for which, as we understand, they already have authority." Please comment on this statement.

RESPONSE: Section 6 of S. 2149 would amend section 1826 of title 38, United States Code, to expand VA's authority to collect housing loan debts by offsetting a debtor's Federal tax refund. Currently, section 1826 prohibits offset of any non-VA Federal payment to satisfy an indebtedness to VA arising out of the Loan Guaranty Program unless the debtor consents in writing, or a court has determined that the debtor is liable to the VA. Since a significant number of VA guaranteed loans are foreclosed nonjudicially, these requirements are often not met and the offset cannot be accomplished.

We believe that the Deficit Reduction Act of 1984, Pub. L. 98-369, established a policy of collecting Federal debts through offset of federal tax refunds and that conforming amendments should be made to section 1826 of title 38.

QUESTION 18: Section 4(b)(2) of S. 2149 would allow the VA to suspend from participation in the VA manufactured home loan program "a manufacturer who has engaged in procedures or practices determined by the Administrator to be unfair or prejudicial to veterans or to the Government." Section 1819(k) of title 38, United States Code, already provides the Administrator with broad authority to refuse to guarantee or make loans to purchase manufactured homes from dealers who have engaged in "unfair or prejudicial" conduct or to approve manufactured home sites owned by persons engaging in such conduct. Since section 1819(g) also provides that the Administrator "shall promulgate such regulations as the Administrator determines to be necessary or appropriate in order to fully implement the provisions" of the manufactured home loan program, could not the Administrator achieve the purpose of section 4 by regulation?

RESPONSE: We believe VA has an inherent authority to suspend participants for just cause. However, because the provisions of the law applicable to suspending other loan guaranty program participants specifically authorize suspension for engaging in practices prejudicial to veterans or to the Government (38 U.S.C. 1804(b) and (d) and 1819(k) we believe a technical correction is needed to make clear that VA has the the same authority with regard to manufacturers who engage in such practices.

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

QUESTION 1.

Please describe the role played by Disabled Veterans Outreach Program (DVOP) staff in preparing disabled veterans for employment when they have completed training. Do you have any suggestions for improvement in the role these DVOP's play in preparing and placing these veterans?

RESPONSE: Disabled Veterans Outreach Program (DVOP) staff play a vital supportive role for graduates of the VA's Chapter 31 program. DVOP's, as part of the Employment Security System, are utilized as experts in the field since they are tied in with not only the database of the employment security system but with the numerous private sector employers they come in contact with on a daily basis. Additionally, as disabled veterans themselves, they serve as role models and are uniquely qualified to relate to the hardships which are likely to befall a disabled veteran seeking employment. With regard to improvement in their role, we support the training which is now taking place at the National Veterans Training Institute, and envision having some of our own personnel attend to improve their placement skills.

QUESTION 2.

What role do VA "Career Development Centers" (CDC's) play in the vocational rehabilitation process? Do you have data on the number of disabled veterans who use this resource? Do you have data on the usefulness of the CDC's?

RESPONSE: Over the last few years the chapter 31 program has been modified and redirected in order to implement the requirements of PL 96-466. As a part of this effort, Career Development Centers were integrated and are now included in Vocational Rehabilitation and Counseling Divisions in regional offices. Nearly all disabled veterans receiving chapter 31 services have interaction with and benefit from the element of VR&C formerly identified as the Career Development Center. Disabled and other veterans are provided with current career and job information, training in job-finding skills and approaches, and direct placement contacts or appropriate referral for job placement assistance. This kind of direct help to the veteran is viewed as vital to carrying out the mission of rehabilitating service-disabled veterans.

QUESTION 3.

What has been the impact of delays in integrating the Chapter 31 program into TARGET on VA's ability to provide vocational rehabilitation services? What barriers or problems stand between you and phase II of your TARGET modernization project?

RESPONSE: The current payment system is limited and vulnerable. These limited and vulnerable areas will be eliminated with the installation of our Phase II Target effort. Despite our priority status, the Phase II effort has been delayed due to the shift of significant resources to other ADP initiatives of higher priority. At this time, an installation date of late in 1989 is scheduled.

QUESTION 4.

You indicate one reason for the apparent delay in rehabilitation of disabled veterans who complete Chapter 31 training is the veteran's decision to pursue additional higher education. In FY 1987 what percent of the veterans who completed Chapter 31 training had their determination of rehabilitation delayed for this reason?

RESPONSE: The comment concerning veterans who complete training under chapter 31 and then elect to pursue additional higher education was based upon anecdotal reports from various field stations rather than any quantitative data systematically collected from the system. The program completion reason codes are being reviewed as a part of the phase II TARGET and this type of information will be collected as part of the program management. While it is believed that this does not represent a large number of veterans it is particularly frustrating to the field staff as these individuals do represent successful individuals who have frequently qualified for tuition assistance and help from other sources and due to the definition of rehabilitated status these successes are not fully acknowledged by the system.

QUESTION 5.

How many disabled veterans have been placed in non or nominally paid Federal on-the-job training or work experience programs? With what result? How many obtained paid employment? How many are still working?

RESPONSE: In 1987, 300 veterans participated in non-pay OJT programs in Federal agencies. These programs were developed with specific position criteria that ensures that successful trainees are qualified and employable at the end of the training program. The placement record for successful participants in this program is over 90 percent. The veteran is declared rehabilitated at the completion of 90 days successful employment and no records are available concerning continued employment after that time.

Work experience may be provided to a veteran participating in chapter 31 for any one of the following reasons:

o To evaluate physical stamina and functioning in a work setting preliminary to a program of training.

o To provide work experience for improving existing skills to a competitive level preliminary to employment services.

o To provide work experience subsequent to formal training and in conjunction with a job search either within the Federal or private sector.

Due to the diverse types of programs and different objectives that lead to the rehabilitation goal, a definitive outcome by program is not available although the work experience is in certain cases a valuable rehabilitation strategy. Work experience was utilized by 196 veterans in 1987.

QUESTION 6.

What steps have you taken to overcome the challenges to rehabilitation presented by disabilities, such as mental illness or PTSD, which affect an individual's behavior?

- With what results?

- What percentage of your clients have neuropsychiatric disabilities or PTSD?

RESPONSE: We have placed an emphasis on VR&C field staff developing a closer working relationship with the Vet Center program in order to motivate Vet Center clients to enter formal rehabilitation planning and to involve Vet Center staff resources in the case management of veterans with neuropsychiatric disabilities or PTSD. We have instituted a working relationship with the Department of Medicine and Surgery to obtain neuropsychological evaluations of closed head brain injury. Further, in FY 87 we conducted 6 regional training conferences for the total VR&C field staff. Twenty percent of this training focused on neuropsychological assessment and the rehabilitation of veterans with behavioral disorders.

The results of our efforts are not readily available since success with the rehabilitation of persons having mental illness, PTSD, and brain damage related behavioral disorders is traditionally at a very low level and positive results are rarely seen in the short term.

Currently, of the 24,175 veterans receiving rehabilitation services through the chapter 31 program, 18 percent are rated for mental disorders and an additional 9 percent have neurological disabilities which include behavioral disorders associated with closed head brain injuries.

QUESTION 7.

You state you are "working with" employers to increase employment opportunities for Chapter 31 disabled veterans. What precisely are you doing?

RESPONSE: One method which demonstrates our increased activity with working with employers concerns mass mailings. Early this year we mailed material promoting the chapter 31 program and disabled veterans in general to 26,000 private employers around the country who had previously indicated their support for hiring veterans. Additionally, this 26,000 private-sector employer list has been broken down by state and supplied to each regional office for use in local outreach efforts. Another project which demonstrates our working with the private-sector is our liaison with Lockheed Corporation. This major employer placed an advertisement promoting the employment of disabled veterans in Aviation Week and Space Technology, which is subscribed to by approximately 150,000 individuals, with a conservative "pass on" readership of nearly 500,000.

Question: 8. What is the status of implementing provisions contained in Public Law 100-322 which deal with recruitment and retention of health-care professionals -- specifically, tuition reimbursement and bonus pay programs?

Answer: An Ad Hoc Advisory Group is being formed to advise the Chief Medical Director on legal, policy and operational matters regarding the tuition reimbursement program. This group is composed of VACO staff, field staff and a representative for college/university schools of nursing. The first meeting of the group is planned for July. It is anticipated that the tuition reimbursement program will be a positive component of VA recruitment and retention efforts.

Section 212 provides for the payment of bonuses to RNs and other shortage categories of health care employees at the discretion of the Administrator when necessary to recruit and retain these employees at facilities designated by the Administrator as having a significant shortage. The Agency is examining legal issues associated with implementing the new authority. Implementing policy will be developed, and it is expected that this program will be activated in the VA in early calendar year 1989.

Question: 9. In May I received a letter from Mr. Turnage which requested $500,000 in additional funds for the Philippines. VA officials have stated that this amount "is a drop-in-the-bucket" compared to what is needed for the facility in the Republic of the Philippines.

Does the VA have a plan which identifies the needs in the Philippines and what kind of financial commitment will be needed in the future by the VA?

Answer: The VA does not at this time have a final plan reflecting the relative priorities among the major items needed. There are several major projects, however, which require immediate attention. Major work needs to be accomplished on the roof of the medical center. During the rainy season some hallways and wards experience flooding. The central water system needs major work to insure that sanitized water is available throughout the facility. In addition, there is no emergency backup power system for the hospital which poses a serious problem for patients on respirators during periods of local power failure.

Following are some projects and equipment purchases which could be accomplished during FY 1989:

Projects	Est. Costs
Emergency Generator	$ 90,000
Roof Repairs/Waterproofing	120,000
Water Distribution System	150,000
Rehabilitation Medicine Renovation	40,000
Subtotal	$400,000
Equipment	
Radiology Equipment (1 X-Ray Unit & 2 Ultra Sound Units)	$430,000
Rehabilitation Medicine Equip.	70,000
I.C.U. Monitoring System	100,000
Subtotal	600,000
Grand Total	$1,000,000

Completion and procurement of the above items would have a very positive and immediate impact on patient care at the VMMC, however, much remains to be accomplished. For example, the Central Services area, which provides sterile supplies, distilled water and medical supplies, etc., needs renovation and re-equipping to include water, electrical and steam lines. All 19 active wards are in need of renovation. The Laboratory, Emergency Room, Pharmacy, Morgue, Medical Library, and Research areas also need renovation and upgrading.

QUESTION 10.

Your testimony indicated that the VA does not support my bill, S. 2207. The VA would support a pilot program of providing simians to quadriplegics.

- Under my bill, could you not choose to implement this authority as a pilot program?

RESPONSE: The concept of a "simian aide pilot program" is, of course, rather general. A test program whose focus was solely provision of trained monkeys to a specified number of veterans could certainly be set up under S. 2207. An initiative aimed at resolving the many logistical problems we envisioned would, in our view, require a statutory basis broader than S. 2207.

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